ABSTRACT OF A

Clinical Lecture

ON THE

DIFFERENTIAL DIAGNOSIS BETWEEN CERTAIN HYSTERICAL CONDITIONS AND MYELITIS.

Delivered at the National Hospital for the Paralysed and Epileptic, on Dec. 16th, 1880,

BY THOMAS BUZZARD, M.D., F.R.C.P.

GENTLEMEN,—The subject of nervous mimicry of organic disease in general has been, as you are well aware, admirably discussed by Sir James Paget. It is not my intention to take up your time by attempts to add anything of importance on the general question to the account which we owe to one whose unrivalled experience has been recorded with consummate literary skill. But I wish to bring before you to-day some cases of recent occurrence to illustrate the difficulties which often occur in distinguishing between certain forms of acute and chronic myelitis, and hysterical imitations of the symptoms belonging to such conditions. Opportunity will thus be given me for referring to points of diagnosis that may assist in preserving us from errors which are of very frequent occurrence. I may say at once that it is often extremely difficult, and occasionally for a long time impossible, to arrive at a confident opinion in cases of this kind. Yet, unless we can do so, should the case be one of hysteria, we stand little or no chance of curing our patient, and for obvious reasons it is a still more serious matter if we mistake a case of organic disease of the spinal cord for one of hysteria.

But, first, let me mention the forms of disease of the spinal cord which, according to my observation, are the most likely to be confounded with hysteria, and I will here refer to Grasset's classification. On the side of *systematic* myelitis there is first spastic spinal paralysis from sclerosis of the lateral columns of the cord, and next acute anterior polio-myelitis, that affection of the anterior cornua upon which I lectured last week. In my experience tabes dorsalis is rarely or never imitated by hysteria. I certainly did see not long ago a lady in whom a complete and temporary loss of the muscular sense in the lower extremities imitated one of the symptoms of locomotor ataxia, and produced a slight incoördination in the gait, but the diagnosis was easy, owing to the entire absence of any corroborative symptoms. On the side of *diffuse* myelitis—i.e., myelitis invading without distinction any or all of the regions of the cord,—two forms alone need special reference. Of the first, a circumscribed and subacute variety (most often perhaps when it attacks the dorso-lumbar region); of the second, that special form which we know as insular or disseminated cerebro-spinal sclerosis. Of this last I shall only say now that it is as regards this form of myelitis, and its imitation by hysteria, according to what I have seen, that an insuperable difficulty of diagnosis is very apt to occur. I propose to reserve this important variety for consideration in a future lecture. On the present occasion I shall refer to cases in which subacute myelitis, anterior polio-myelitis, and lateral sclerosis come in question.

Early in last summer a school-girl, aged fourteen, was admitted into the hospital unable to stand without support. She could not walk, but with a stick in one hand and an arm to lean upon, she would advance, like a kangaroo, by a series of springs. It was said she could spring up three stairs at a time. Her ankles were constantly kept bound firmly together, and with this arrangement she was comfortable enough. When, however, the bandage was removed there was sudden, instantaneous adduction and rotation inwards of the knees, and consequent separation of the ankles, each foot being at the same time turned strongly inwards. In its rapidity the movement resembled the action of a gunlock. The muscles would then be found rigidly contracted, and the girl would cry out with the pain which the spasm evidently occasioned her. The patellar tendon-reflex was in excess on each side, and there was also ankle clonus. From notes taken by Mr. Broster, it appears that about two years previously some water had been let fall from above on her head (just behind the right ear) as she looked out of window. This gave her a very great shock, and was followed by earache, headache, gradually increasing deafness, and in three months by a state of delirium and "childishness," with loss of sight, hearing, taste, and smell. The delirium lasted a week. After this there was great pain in the head, and the legs and arms used to be violently drawn and twitched. There was also from the description some opisthotonos. These symptoms continued for two or three months. The sight then returned suddenly, the spasms grew less, the hearing and sense of smell were restored, and she gradually got into the state exhibited on admission, in which she had then remained for a twelvemonth. The strongest faradaic currents producing a slight and only temporary relaxation of the rigidity, the girl, on the sixth day of her admission into hospital, was placed under the influence of ether, and as she became insensible the muscles relaxed. She was then allowed to recover; but when consciousness had apparently only half returned, the legs resumed with extreme suddenness their position of adduction and rotation inwards. They were not, however, now so rigid, and she was induced (intoxicated by ether as she still was) to stand and walk feebly. She was then again (and still more completely) anæsthetised, and whilst unconscious the legs were rotated outwards and abducted. This time they retained their new position when the girl recovered consciousness. The left foot was then perfectly straight, but there was still some inversion of the right. In this one ankle clonus could still be readily obtained by dorsal flexion, and also, though to a less degree, in the left foot. After this there was no return of rigidity, and on the following day she walked well. A week after the etherisation no ankle clonus could be induced. She was sent home perfectly well within a fortnight of her admission. I heard the other day that she is in excellent health.

We had the advantage here of a *complete* history, and the diagnosis was easy. But I can quite understand that during the progress of this case there must have been difficulty especially in excluding cerebral and probably spinal meningitis, and that the rigidity with exaggerated reflex would have a *primâ facie* resemblance to that arising from sclerosis of the lateral columns secondary to a lesion above. But the course of the disease—and especially the opisthotonos followed by *sudden* return of sight—was conclusive of hysteria. Moreover, had the rigidity depended on bilateral sclerosis, the jumping feats would have been absolutely impossible. Added to this, the gluteus maximus, the most important muscle in jumping, is also a rotator outwards, and this movement had been in complete abeyance—an inconsistency of the most striking kind. Now, this girl recovered rapidly because we were absolutely sure of our diagnosis. You cannot cure a case of hysteria so long as you have any serious doubts about its nature.

In the diagram before us (drawn from photographs which Dr. Gowers kindly took for me) are two pairs of feet, which present a certain superficial resemblance. In each the inner

border is drawn up into the position of a not severe varus. They are the feet of two young women who were in the hospital at the same time, and there is this special point of

interest about them, that F——, really a case of acute myelitis, had been treated as a case of hysteria, and B——, really a case of hysteria, came in as a paralytic. I show you the patient F——. This girl, aged sixteen, was admitted last April, on account of loss of power in both her legs, which had existed for three months. In the early days of her illness she had been treated by cold shower-baths administered daily, and strong currents from a magneto-electric machine to her legs, continued, she says, every day for a month. The history of her symptoms is briefly as follows. A feeling of pins and needles from the waist downwards was followed next day by weakness and pain in the legs, and on the following morning by total inability to move them, and complete anæsthesia. Some bladder trouble occurred for nine days, and want of control of bowels (from her account) for some weeks. Her description, however, is not very clear on this point. Two months after her attack she for the first time succeeded in moving her left leg. The right could not be moved till five weeks later; sensation returned in the left leg six weeks after the onset, and a week later in the right. When she came here she could lift the left heel two feet off the bed, and bend the knee. On the right side she could only make the faintest effort at flexing the hip and ankle-joint, and could not bend the knee. The right foot lay in a position of talipes varus, which could be reduced by the hand, but not by the patient's volition. The patellar tendon-reflex and sole-reflex were absent on the right side, feeble on the left. The electrical examination was most important. Whilst the muscles of the *left* limb responded to induced currents but little stronger than normal, the peroneus longus of the right side showed no reaction to the greatest strength of Stöhrer's two-celled induction-machine, and the anterior tibial group required much stronger currents than in health. The right quadriceps extensor failed to contract to either induced or voltaic current. At the present time the right peroneus longus reacts to interruptions of twenty to thirty cells voltaic current, the vastus internus to sixteen cells, the externus to twenty cells. None of these muscles react to faradaism, to which the tibialis anticus alone responds nearly normally. The tibialis anticus, which has all along been less affected than the other muscles, determines the position of the foot, its antagonist, the peroneus longus, which holds down the head of the first metatarsal bone being paralysed.

In this case the electrical examination alone is sufficient to exclude hysteria. Duchenne wrote that the electro-muscular contractility was normal in hysterical paralysis. According to my observations there are exceptions to this, which, however, is doubtless the rule. Occasionally there is a distinct, although slight, lowering of electrical excitability in the muscles in hysterical paralysis, where this has been of long duration. The lowering of excitability, however, applies to both forms of electrical excitation, and in that respect differs from the "reaction of degeneration" where the decrease in faradaic excitability is usually accompanied by increased excitability to the voltaic current. We *never* see in hysteria the various muscles of one limb showing differing degrees of abnormality of response to faradaism, from a condition of total absence perhaps in some, to nearly a natural state in others. Moreover, according to my observation, in hysteria applications of electrical stimulus (and especially of the voltaic current) on one or two occasions usually suffice to restore the natural excitability of the muscles (equally in all), which has simply declined apparently through disuse. A difficulty can only arise where the observer has but one opportunity of testing the electrical condition, and it is then quite possible to occur. It must be remembered that, as a distinct lowering of faradaic excitability almost invariably signifies organic change in a nerve or nerve centre, a diagnosis of hysteria can never safely be arrived at whilst that condition persists. On the other hand, I need scarcely remind you that the preservation of a completely normal faradaic excitability in the muscles of a limb does not show that that limb is not paralysed. It would be hardly necessary to refer to this, but that I once heard it stated in a court of law that the plaintiff was certainly not paralysed, since the muscles of the limbs contracted to electrical currents! In cases of paralysis, it is only when the integrity of the grey matter of the anterior horn is disturbed, or when there is some lesion of the anterior root of the nerve, that you find decided loss of electric excitability. You may have, and frequently do have, complete paraplegia with all the muscles responding normally.

As regards the patellar tendon-reflex, I have never seen it lost in a case which proved in the sequel to be hysterical, although I am not prepared to deny the possibility of its absence in such circumstances, if the muscle has suffered from lengthened disuse.

The other patient, B——, aged twenty-four, came in unable to stand without support. In trying to walk between two persons the left foot was seen to be in a position of varus, as shown in diagram, and as she lay in bed the foot occupied the same position, although it was not then quite so determined. Now, in her case the faradaic excitability of the muscles of both lower extremities was found to be quite normal. The patellar tendon-reflex was very excessive on both sides, and most marked on the left. There was no ankle clonus. The sole-reflex in the left foot appeared normal. In the right tickling was at first followed by no response, but being persevered in the limbs drew up strongly. After the daily use of the wire brush, with induced currents, for two or three weeks, and general treatment, the patient was able to walk round Queen-square without help; next day a still longer distance, and soon went out of the hospital recovered.

Now this patient had suffered for three years from convulsive fits, in which she was described as losing her consciousness. The occurrence of fits in such cases as these may materially aid our diagnosis, or, on the other hand, may lead us into error. Supposing that the patient who is apparently paralysed has attacks of typical hysterical eclampsia, we have in them a symptom which, when associated with others, may tend to render a diagnosis of hysteria certain. In the present instance, although the first fit occurred after the patient had been frightened by being locked up in a room, and was therefore presumably hysterical, the attacks, some of which were witnessed in the hospital, were of an epileptoid rather than hysterical character, and their occurrence lent us no aid. As I said just now, they may easily lead to error. About a year ago I admitted a young woman on account of paralysis in all four limbs. She was described by those who sought admission for her as a case of hysterical paralysis. Seven months before she came here the patient had complained of pain in her back, side, and head. The pain was very bad on the vertex. Next she became very weak on her legs, and moved them in an incoördinate manner. At this time there was great weakness of the right hand, and the right side of the face was paralysed. Soon she became unable to walk at all.

A month after she had begun to be ill this patient had a fit, and these had been repeated on five or six occasions before her admission. I have little doubt that it was the occurrence of these fits, associated as they were with paralytic symptoms, confined at first to the lower extremities, which gave rise to the diagnosis of hysteria in this instance. The apparent want of connexion between the two symptoms would be suggestive (unless the possible existence of multiple lesion were insisted upon) of the inconsistencies of certain forms of hysteria.

When we came to examine this patient with the ophthalmoscope (which we never omit doing), it was found that she had optic neuritis. This fact, of course, immediately carried us a long way on to a diagnosis of serious brain lesion. Moreover, in addition to this she had a bedsore, and the presence of this alone was significative of organic disease.

Let me call your attention to the note respecting the state of the muscles of this patient's legs on admission. "Lower limbs powerless; not the slightest power of movement; *no wasting*, no rigidity. No difference between the two limbs. The muscles respond to faradaic currents of somewhat higher strength than is required normally." (As the case advanced there was much wasting, and the legs were rigidly drawn up.) I shall have occasion to refer to the question of wasting of muscles and its diagnostic value. For my present purpose it is only necessary to add that this patient grew worse and worse, that in spite of the most diligent attention her bedsores extended, and that she died some months after admission. The autopsy showed basilar meningitis and spinal meningo-myelitis, the cord being disorganised and softened throughout. The patient, it should be said, was the subject of inherited syphilis.

I lately saw in consultation in the course of a week three ladies, each of whom had been thought to be suffering from hysterical paralysis, although in two cases there had been some difference of opinion on the part of those who had seen the patient. The first proved to be a case of advanced

Pott's disease of the spinal column with paraplegia. The second was an example of anterior polio-myelitis. Three months previously this patient, a lady aged twenty-six, had been attacked with feverishness, pain in the back, and aching in the legs. The following morning she was weak in her legs, and next day had entirely lost the use of them. There was no affection of sensibility or of the bladder. I found the patellar tendon-reflex absent in each limb, the muscles of both thighs wasted and flabby. Powerfully supported she could move her legs a very little, but both feet were dropped. The cutaneous-reflex from the sole was good on each side. I learned from the gentleman in attendance, who (as it happens) is able to give skilled evidence on the point, that when examined electrically a short time previously to my visit, the muscles gave typical "reaction of degeneration" in varying degrees. I found that percussion produced contraction in the right tibialis anticus and peroneus longus, but not in the left. The "reaction of degeneration" and the varying degrees of response to mechanical and electrical stimulation showed conclusively that the case was not one of hysteria. It is an example of acute anterior polio-myelitis. The third patient had been paralysed in both legs for two and a half years, and in the left arm for nine months. Uterine troubles and pelvic cellulitis had preceded the paralysis, and an abscess had discharged through the bladder. The loss of power had been gradual, and took a few months to become complete. It was accompanied by cramps and some loss of sensation. The patient was in bed, and unable to move her legs at all, and the feet were dropped; the legs were wasted. There had never been bedsores. The urine (always acid) had been drawn off for two years, the use of the catheter having commenced, as I learned, in connexion with the local troubles of the bladder from the abscess. The patellar tendon-reflex was here distinctly present, but not strong, on each side. Tickling the soles was not felt, and produced no reflex. The legs were not contracted, but the joints were somewhat stiff. Strong induced currents were not felt, and there was not at first free response of contraction in the muscles. A strong constant current was then applied, and the interruptions of this the patient felt very much. A return being then made to faradaism the currents were now felt acutely, and the contraction of the muscles became nearly normal, in proportion to their wasted bulk. Moreover, the muscles of the thighs were now used in a quasi-voluntary manner to draw up the legs in an endeavour, as it appeared, to escape the painful application. The left arm, which lay across the chest, was neither rigid nor lax, but as if asleep. When the patient's attention was engaged in another direction the arm was held up, and being then let go, it subsided gradually and slowly. A strong opinion was expressed that the condition was hysterical, chiefly on the following grounds. The gradual loss of power, with loss of sensation if it were organic, must have been due to more or less diffuse myelitis, involving grey as well as white matter. The situation of this must have been either in the lumbar portion of the cord, whence the nerves proceed to the lower extremities, or at some point above this. Had it been in the former, the patellar tendon-reflex would have been absent, and the muscles would have lost their faradaic excitability. If it had been above there would necessarily have been by this time descending degenerative changes in the lateral columns, which would have shown themselves by more or less rigidity and exaggerated reflex. Had myelitis been so extensive as to involve the whole of the lower half of the cord in softening, there must have been bedsores and difficulties with the rectum. The result of the case has justified the opinion which was arrived at by those who consulted upon it. Under careful feeding, moral treatment, and faradisation of the skin with the wire brush, the patient speedily regained the use of the arm, was shortly afterwards able to walk to a certain extent, and is now, as I learn, quite recovered.

In this case, as I have seen in many belonging to the class of hysteria, the epidermis, which had arrived at extraordinary thickness, apparently from disuse of the limbs, offered great resistance to the passage of electric currents. In these circumstances a more than usual amount of care in thorough soaking and rubbing of the skin, as well as in selecting the motor point, is necessary in order to avoid fallacies.[1] This woman's legs were very thin. There is, I think, a very common notion that the existence of wasting negatives hysteria. But a disused limb is of course liable to emaciate. The only way to distinguish with certainty between this wasting and that which arises from change in the trophic centre in the spinal cord, or from disease of a nerve-trunk, is by observing the condition of faradaic excitability, and seeking for any qualitative changes on interruption of the voltaic current. I have reason to think that not a few cases of anterior acute polio-myelitis occurring in young females pass as examples of hysterical paraplegia, owing to omission to test carefully the state of the muscles by electrical currents. Such cases may sometimes recover in the course of several months, and then the result is supposed to prove the truth of the diagnosis.

Absence of reflex from the sole of the foot is a very constant symptom in hysterical paraplegia. Where this coexists with normal electrical contractility of the muscles of the lower extremities and normal tendon-reflex the case may be looked upon with suspicion, although this is not of itself sufficient to exclude organic disease. A persistence in the application of a stimulus to the sole will, in hysterical cases, frequently, but not always, succeed in a few minutes in provoking a response.

Preservation of the roundness and firmness of a limb is often thought to be incompatible with paralysis. This is a dangerous error. In the case of Pott's disease, which I have referred to (the patient died a few weeks afterwards), the lower extremities were rounded, well nourished, and firm to the touch. In cases of localised myelitis of the dorsal region of the cord, followed by descending sclerosis of the lateral columns, there is frequently unusual firmness and tonicity of the lower extremities, which may appear, indeed, to be models of muscular development. This is important to remember, as hysterical imitations of lateral sclerosis are not uncommon. The most frequent, however, and at the same time the most difficult of distinction, is a condition closely resembling disseminated cerebro-spinal sclerosis. This must be reserved for future consideration.

[1] As the motor point frequently varies as regards its position from that indicated in works on electro-therapeutics, I am in the habit of testing in the following manner: The limb having been very thoroughly wetted and rubbed with hot water, and the induction machine arranged to give a somewhat stronger current than is necessary in health, one rheophore is applied to an indifferent part of the body (as e.g. the sacral region), and the other is moved about the skin of the limb at the part where the motor point is expected to be found. It will soon be perceived, by comparison, at what point of application the most energetic contraction is excited. The skin is then marked at this spot with a wetted aniline pencil, and the operation is repeated on the opposite limb, as well as for other muscles. The motor points having thus been ascertained, it is easy, by graduating the machine, to discover the weakest current which will cause contraction and compare it with that required in health.

A HISTORY OF THREE CASES IN WHICH A WARTY GROWTH WAS REMOVED FROM ONE OF THE VOCAL CORDS BY THE AID OF THE LARYNGOSCOPE.

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IN the 51st volume of the Medico-Chirurgical Transactions I have given the history of seven cases in which I removed warty or papilliomatous growths from the vocal cords. In the present communication I propose to describe briefly three similar cases that have more recently come under my observation and treatment.

CASE 1.—Susannah M——, aged sixty-three, was admitted into Twining ward on Oct. 16th, 1875, on account of hoarseness and dyspnœa. The hoarseness began two years before, and had gradually increased up to the time of admission. About ten weeks previously she began to suffer from difficulty of breathing, especially on exertion. The breathing was attended with a rattling noise in the throat, and sometimes with a sensation as of something flapping about in the upper part of the windpipe. For some time the breathing had been more difficult when lying down at night, and her sleep had been much disturbed in consequence. There had been a feeling of uneasiness, but no actual pain in the throat. She had had but little cough, and no expectoration. There was no difficulty of swallowing. Since the breathing had been difficult she had lost flesh and colour. The voice was now (at the date of admission)

reduced to a whisper, and both inspiration and expiration were attended with a moist, wheezy stridor. On looking into the larynx, the cause of the aphonia and dyspnœa was obvious. Attached to the anterior part of the left vocal cord there was a warty tumour of the size and shape of a small filbert. This wart-like tumour occupied at least two-thirds of the area of the glottis. Although it appeared to have a broad attachment to the vocal cord, it was moved by the current of air, so that it rotated in a downward direction during inspiration, and upwards in expiration. The left vocal cord was entirely concealed by the growth, but the right cord was plainly visible and appeared quite normal.

On the 26th October I made an attempt to remove the growth by the laryngeal écraseur, but the patient was nervous, and her nervousness was increased by seeing a crowd of students surrounding her while watching our proceedings; so after one or two unsuccessful attempts to seize the tumour I determined to wait for a more favourable opportunity. Two days afterwards, on the 28th, I obtained the assistance of the house-physician, Dr. Batterbury, who held the patient's tongue, and I soon succeeded in removing nearly the whole of the growth. First, with the écraseur I pulled off a piece nearly half an inch long; then two smaller pieces by the same means; after which, with the laryngeal-forceps I removed a piece as large as a horse-bean. There was not much bleeding—these growths are not very vascular, and they never bleed much,—but the little bleeding that occurred after the removal of the first piece increased the obstruction of the glottis and caused some temporary dyspnœa. After the removal of the last large piece she expressed a feeling of relief, and the breathing ceased to be stridulous. On the following day she stated that she had slept better than she had done for some weeks past. On inspection we found only a small nodule of the warty growth near the ridge of the glottis. This was afterwards touched on three or four occasions with solid nitrate of silver by means of the laryngeal porte-caustique, and it entirely disappeared. Her voice was completely restored.

The laryngoscope enabled us in this case not only to make an exact diagnosis, but also to remove a disease which ere long would have caused a fatal impediment to respiration. A few years ago, before that simple instrument had been brought into use, we could only have guessed at the nature of the disease, and we should most likely have guessed wrong. The result would probably have been that when the growth increased until it threatened life, tracheotomy would have been performed, and for the rest of her days the voiceless patient would have breathed through the artificial opening in her windpipe. How much happier is the result obtained by the aid of the mirror, not only affording relief from impending suffocation, but complete restoration of the voice.

We know from our experience of similar cases that when a simple warty growth of this kind has been completely removed there is little or no tendency to a return of the disease. I have lately seen two of the cases recorded in my paper in the Medico-Chirurgical Transactions—Cases 4 and 7, one ten years, and the other more than seven years after the removal of the growth. In both cases the larynx remains healthy, and the voice is perfect.

CASE 2.—Mr. G. M. S——, aged fifty, first consulted me on Sept. 7th, 1874. His voice had been feeble since the beginning of the year, and latterly had become more and more so. At the time of his visit the voice was reduced to a rough whisper. A few days before I saw him he had been examined by a laryngoscopist, who told him that he had a growth in his larynx which, if not speedily removed, would increase until it suffocated him. I found a simple warty (papillomatous) growth, about the size of a pea, attached to the right vocal cord near its anterior end, and I advised him to have it removed. He was then living in Scotland, and he said that he must return home at once, but he would come to London in November and submit to the necessary treatment. He, however, did not present himself again until February, 1875, when he stated that five weeks before he had caught a severe cold, which had greatly increased his hoarseness. He was then suffering from bronchial catarrh, limited, however, to the larger bronchi. There was much congestion of the palate and fauces. Inspection of the larynx showed that the growth had now attained the size of a large horse-bean. The patient was very nervous and anxious about himself, and the more so as a most unfavourable opinion of his case had been given by a country practitioner; but he had now come to reside in London, and was prepared to submit to any treatment that was thought necessary. The treatment was rendered unusually difficult by the patient's nervousness, and the extreme sensibility of the fauces. By degrees, however, and after several sittings, the greater part of the growth was removed, partly by the forceps, and partly by the écraseur, but there still remained a broad base of attachment to the vocal cord. This I touched several times with solid nitrate of silver. Each touch of the caustic appeared to cause a shrinking of the remaining growth, until at length, after about three months' treatment, the cord was left smooth and healthy, and the voice was completely restored. This gentleman continues in good health. I have seen him during this present month (Jan., 1881). His voice is quite clear and strong, and inspection by the mirror shows a perfectly healthy larynx. While under treatment he took great interest in my proceedings, and suggested to me a very ingenious metal guard which I had placed on one side of the forceps so as to protect the side of the larynx opposite to the tumour from injury when the forceps are closed. The cure of the preceding case was more troublesome and prolonged, although ultimately complete, than that of any other similar case that I have met with. On the other hand, in the following case I succeeded in effecting an unusually rapid cure.

CASE 3.—The Rev. J. R——, aged about fifty, consulted me first on the 2nd October, 1880. For about a year there had been more or less discomfort in the throat, which was much increased by the excitement of the late election, during which he talked much in spite of the pain and inconvenience it occasioned. The result was, as he states in a written history which he gave me, that his "throat became painful and the voice cracky," and he "felt sometimes as if he was being half strangled." At the time of his visit the voice was rather feeble, and had a reedy sound. He had been told by a laryngoscopist a few days before that there was a small growth on one vocal cord, the removal of which was recommended, but pronounced difficult and doubtful on account of its small size. I found a bright-red wart, about the size of a No. 4 shot, attached to the right vocal cord at its anterior extremity. Although of small size it was sufficiently movable by the respiratory currents of air to fall below the glottis during inspiration, while it was driven upwards and interposed between the cords during vocalisation. The patient was very anxious to have the growth removed, and on October 29th he called to make an appointment for the following day, when the attempt for its removal was to be made. Accordingly he came on the morning of the 30th. It appeared to me scarcely possible to seize so small a growth with the forceps, and I determined to use the écraseur. The first attempt was a failure, but at the second introduction of the instrument I succeeded in seizing and completely removing the entire growth, much to the delight of the patient, whose visit did not occupy altogether more than a quarter of an hour. I last saw him on Nov. 5th, when he called and expressed himself much relieved, and as regarded his throat quite well.

With respect to the kind of instrument best suited for the removal of such growths. When the tumour is of large size and has a broad base, as in the first and second cases here recorded, the laryngeal forceps is perhaps a better instrument than the wire écraseur. I found the forceps very useful in the first two cases, but for the removal of so small a growth as that in the third case I much prefer the écraseur; and I doubt whether this small growth could have been safely removed by the forceps.

The écraseur has this obvious advantage over any form of laryngeal forceps, that, unlike them, it very rarely tears the mucous membrane or seizes any other object than the growth to be removed. It is a perfectly safe and harmless instrument, whereas with the forceps an arytenoid cartilage might be seized and broken or dislocated. The secret of success in using the écraseur consists in bringing the fine steel wire loop exactly opposite the wart at the time when the contact of the instrument excites the sudden closure of the glottis, by which means the tumour is driven into the snare and caught by the sudden retraction of the wire. I have always found that any portions of the morbid growths that are torn off have been tightly held by the wire, which, partially cutting them through and embedding itself in their substance, thus brings them away. I have no reason to suppose that any detached bits of tumour have fallen into the trachea. If, however, this were to happen no harm would result from it; they would probably be expectorated as readily as small masses of mucus are expelled.

Savile-row, W.

CASES OF LARGE CALCULI REMOVED FROM THE BLADDER BY BIGELOW'S OPERATION.

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SURGEON TO THE WEST LONDON HOSPITAL.

THE cases I am about to relate are, for many reasons, especially interesting, and prove what Bigelow's operation can accomplish even when the presence of stone is complicated by the existence of grave constitutional disease. The calculi were, I believe, the largest single ones recorded as ever having been removed in this country from the bladder by lithotrity at one sitting. If reference be made to the cases published by Sir Henry Thompson, it will be seen that the weight of the largest stone completely removed by him at one sitting was only 275 grains, whereas the calculi from my patients weighed respectively 486, 610, 880, and 890 grains. One of the patients was suffering from diabetes, another from paralysis. The youngest was fifty-six years old, the eldest seventy-seven. They all made good recoveries, which, with one exception, were very rapid.

I read the results of my first series of one hundred consecutive cases of operation for stone in the bladder at the annual meeting of the British Medical Association at Cork in August, 1879. That series did not include a single instance of Bigelow's operation, for I did not perform my first case of it till six weeks afterwards. Since the above date I have operated on twenty-six patients for stone in the bladder. One of them was a boy, whom I cut by the lateral method, and cured. Three of the adult males were submitted to fragmentation and median lithotomy. I should have preferred lithotrity and external urethrotomy, but the combination was not practicable. Of these, two gentlemen recovered, and one hospital patient, aged sixty-one, died three weeks after the operation from chronic interstitial nephritis. The remaining twenty-two adult males were all relieved of their calculi by lithotrity at one sitting. Of these two died. One of the deaths was that of a gentleman seventy-four years of age, a patient of Dr. Hubbard's, who died three days after the operation. I crushed the stone, which was not much larger than a hazel-nut, with a slender lithotrite, but was unable to pass any evacuating catheter over the very enlarged prostate. From the extent and nature of the hæmorrhage which occurred at times before the operation, and was started at it and persisted, I am led to the conclusion that there was a malignant growth in the bladder; indeed, a week before the operation I said to Dr. Hubbard that "I hoped there was nothing more than the stone." I have been informed by a hospital surgeon of a similar case in his private practice, terminating fatally. The other death was that of an emaciated, broken-down, dissipated man, sixty-nine years old, who died apparently from shock thirty hours after the operation. The post-mortem disclosed chronic cystitis and interstitial nephritis. The stone was phosphatic and weighed 220 grains. I would here wish to refer to the case of a gentleman, fifty-six years old, a patient of Dr. Lionel Beale's, upon whom I operated. He was suffering from asthma and chronic heart disease, and had had hæmoptysis. A week after the removal of a uric-acid calculus weighing 160 grains he was completely cured so far as the surgeon was concerned. He was absolutely free from all pain and could hold his urine, which was quite clear and healthy, for six hours. About a month after the operation his legs began to swell, then he was attacked with hæmoptysis, and died about six weeks from the date of the operation. The following is a copy of Dr. Lionel Beale's certificate:—"Old heart disease, asthma, congestion of the lungs, exhaustion."

CASE 1. *Large oxalate of lime calculus in a diabetic gentleman* (FIG. 1).—On July 20th, 1879, in consultation with Dr. Hewer, I sounded Joseph C——, Esq., sixty-four years old. The patient stated that five years ago he consulted Sir H. Thompson, who sounded him but did not find any stone. He was informed that he did not empty his bladder. The examination was followed by a rigor. Four years ago he began to pass blood freely after carriage exercise, and to be troubled with frequent and difficult micturition. For many years he had suffered from diabetes. I introduced a sound, which struck a hard and large calculus as it entered the bladder. As the urethra was of large calibre and the bladder capacious I advised Bigelow's operation. My examination was followed by a rigor. The urine was examined by Dr. George Harley and found to contain oxalates, sugar, and albumen. One year afterwards the patient made up his mind to be operated on, and I saw him on July 6th, in consultation with Dr. Hewer. He was a strongly-built man, with large abdomen. His face was pale and puffy, and there was much capillary congestion of nose and ears. He had habitually a loud, loose cough. The urine, as examined by Dr. George Harley, was acid, contained a little albumen, one grain of sugar to the ounce; the sp. gr. was 1025. There was "a great abundance of mucus corpuscles and vesical epithelium cells, with blood and pus cells and large crystals of oxalate of lime." The gentleman was born in London, but his father was a native of Suffolk. On July 10th at 2.30 P.M. the patient was put under the influence of ether by Mr. Mills. I introduced a large English lithotrite, but was unable to fairly grasp the stone, which slipped away every time I caught it. I then passed Bigelow's lithotrite, and seized the stone, which was 2½ inches in diameter. I then let it go, and having grasped it in its shorter diameter of 1¾ inches, succeeded, in the course of a short time, in breaking it into large pieces, which I further reduced to small fragments and dust with

FIG. 1.

flat-bladed lithotrites. So hard was the calculus that it broke up with loud cracks, distinctly audible to all present. The evacuation of the débris was carried out with No. 26 (F) tube. The operation lasted one hour and a half. The patient was put to bed and his abdomen covered with a large poultice. His diet consisted of milk and barley-water. There was no rise in temperature after the operation, nor was there the slightest hypogastric tenderness. For fifty hours the urine was tinged with blood, and micturition was painful. The patient's progress was rapid and continuous. Five days after the operation he was walking about his garden, and two days later he went for a drive. The weight of the stone, when dried, was fourteen drachms and forty grains. Dr. George Harley pronounced the calculus to be composed of oxalate and carbonate of lime. Dr. Hewer, in a letter recently received from him, thus describes the patient's condition *six months after operation*. "Mr. C—— is quite a different person; able to walk or drive some distance without any discomfort; has lost all his pains. Urine still slightly saccharine. His health is very good. He has a little bronchial irritation occasionally, but that is an old habit of his in the winter." It is worthy of remark that, though the examinations of Sir H. Thompson and myself were followed by rigors, none occurred after the operation, which lasted one hour and a half, during which period numerous instruments were introduced a great many times.

CASE 2. *Large phosphatic stone* (Fig. 2).—George W——, a turner, fifty-six years old, was admitted into St. Peter's

Hospital, on Sept. 21st, 1880, suffering from a stone in his bladder, which I had detected. From notes taken by the house-surgeon, Mr. Whitehouse, it appeared that about two years ago the patient began to be troubled with frequent and painful micturition. The pain was of a scalding character, and extended from the anus to the tip of the penis. He was very pale, and looked much older than he really was, but his body was well-nourished. The urine was rather turbid, acid, and contained oxalates, albumen, and hyaline casts; its sp. gr. was 1016. The man and his parents were all natives of Suffolk. On Oct. 14th at 4 P.M. he was put under the influence of ether by Mr. Knott. As I suspected the stone to be a large one, I incised the meatus externus, and introduced Bigelow's lithotrite, and found the calculus to be 2 in. by 1¾ in. After I had fairly broken it to pieces, I pulverised them with slender flat-bladed lithotrites. The evacuation of the débris was effected with a

FIG. 2.

No. 26 (F.) tube. The operation lasted three-quarters of an hour, when the bladder was examined by Mr. Coulson and Mr. Heycock, and pronounced free of stone. The weight of the stone, when dried, was ascertained by Mr. Whitehouse to be fourteen drachms and fifty grains. The next day the patient had a rigor, the temperature rising to 104·4°, but there was no hypogastric tenderness; the urine was but faintly tinged with blood. On Oct. 17th, the temperature was normal, and the water quite clear; the patient had no pain of any kind, and felt quite well; two days later he left his bed. On Oct. 28th he quitted the hospital in all respects quite well, able to hold his urine for six hours; it was acid, and contained neither albumen nor phosphates. He resumed work shortly afterwards, and has pursued it uninterruptedly to the present time.

CASE 3. *Large uric-acid stone* (Fig. 3).—Robert C——, formerly a farmer, seventy-seven years of age, was admitted into St. Peter's Hospital on Oct. 4th, 1880, suffering from a calculus which I had detected. From notes taken by the house-surgeon, Mr. Whitehouse, it appeared that for some years past the patient had suffered great pain whilst making water. For the last eighteen months his urine had dribbled away night and day. He had a florid, healthy look, but had lost all his teeth, and was feeble and bent. He had a chronic cough. The urine, which was neutral, contained some albumen and phosphates; its sp. gr. was 1012. He was born in Lincolnshire, but did not know where his parents came from. On Oct. 13th, at 2.30 P.M., the patient was put under the influence of ether by Mr. Knott. As the urethra would not permit of the introduction of Bigelow's lithotrite, even after the meatus externus had been incised, I passed a strong fenestrated instrument, and seized the stone, which was apparently spheroidal, and one inch and a half in diameter. Having broken the calculus, which was excessively hard, into fragments, I effected their further reduction with slender flat-bladed lithotrites. The evacuation of the débris was carried out through a No. 24 (F.) tube. The bladder having been examined by Mr. Coulson, Mr. Heycock, and myself, and pronounced free from stone, the patient was put to bed, the operation having occupied an hour and a quarter. The weight of the dried débris, as ascertained by Mr. Whitehouse, was ten drachms and ten grains. No rise of temperature took place after the operation. The patient was usually drowsy, although he passed a large quantity of urine slightly tinged with blood. The variations in the temperature were carefully recorded by Mr. Whitehouse night and morning. On the evening of the 14th it had risen to 102°, and there was a little shivering, but it gradually fell to 98° on the 18th. The urine was slightly tinged with blood for thirty-six hours after the operation. A soft catheter was passed night and morning, and in about a week all dribbling had ceased. On Oct. 20th he first left his bed. The further progress of the case was uninterrupted, and he left the hospital on Oct 24th quite well. A month

FIG. 3.

later the patient called at the hospital to say that he was quite well, and able to hold his urine.

CASE 4. *Medium-sized uric-acid calculus in a paralytic man.* (Fig. 4).—John K——, formerly a farmer, seventy-two years old, was admitted into St. Peter's Hospital on

FIG. 4.

Dec. 2nd, 1880, suffering from stone in the bladder. From notes taken by the house-surgeon, Mr. Neale, it appeared that for three years the patient had suffered from pain at the tip of the penis when making water, which he was obliged to do every quarter of an hour. For about two years he had

not been able to walk, and had suffered from partial incontinence of urine and loss of speech. There was a great deposit of mucus in his urine, which was alkaline, and of a specific gravity of 1022, it contained triple phosphates, but no albumen or casts. The patient had been a large well-built man, but the muscles of the lower extremities were very shrunken and flabby. The man and his parents were all natives of Suffolk. Dr. Althaus, who was kind enough to examine the patient for me, stated that he was suffering from "paralyis dementia, from chronic inflammation of the cineritious substance of the hemispheres." On Dec. 8th at 4 P.M. the man was put under the influence of ether by Mr. Knott. I introduced a Bigelow's lithotrite without having to incise the meatus externus, and seized the stone, which was apparently round, and one inch and three-eighths in diameter. The calculus was exceedingly hard, and I had great difficulty in breaking it up. I used fenestrated and flat-bladed lithotrites for the reduction of the fragments. A No. 26 (F.) evacuating tube was employed to remove the débris. The operation lasted fifty minutes. The bladder was sounded by Mr. Coulson, Mr. Heycock, and myself, but not a fragment could be found. The weight of the dried débris, as ascertained by Mr. Neale, was eight drachms and six grains. Hot poultices were applied to the abdomen, and as there was great smarting when making water a suppository of a quarter of a grain of morphia was administered. For three days after the operation the urine was bloody, but afterwards it contained only some mucus. The patient's recovery was retarded for a fortnight by œdema of the lungs, but he gradually improved and left the hospital on Dec. 29th, absolutely free from all pain, and having a certain amount of control over his bladder and rectum.

Portman-square, W.

THREE CASES OF SUDDEN OBSTRUCTION OF THE ABDOMINAL AORTA BY ANEURISM; WITH REMARKS.[1]

BY J. S. BRISTOWE, M.D., F.R.C.P.

CASE 1. *Aneurism of lower part of thoracic and upper part of abdominal aorta, with complete obstruction of vessel on level of superior mesenteric artery; paraplegia; gangrene of feet; inflammation of bladder, with albuminous urine, &c.; death.*—T. D——, aged forty-two, a gardener, was admitted under Dr. Harley's care on the 31st March, 1880. He had followed his present occupation for a year, previous to which time he had for eighteen years been a railway guard. Five years ago he was laid up with "lumbago and gravel." A year and a half ago he had a severe shaking in a railway tunnel; and about a year since he had "rheumatism" in his back, and gave up work for seven weeks. In all other respects he was healthy and strong, but he has drank freely. He has had no pain or dyspnœa, and has been able to do hard work during the last six months. On the 27th of this month, while returning from work, he suddenly lost the use of his legs and fell down, but neither lost consciousness nor was giddy. Immediately before he fell a pain "took him like a flash of lightning" round the waist. This pain continued for an hour. By the time he reached home (an hour after the onset) he found that his legs were cold and without sensation. On the 28th he began to pass his evacuations involuntarily. Hot water was applied to his legs, and on the 30th bullæ appeared on the back of his thighs, inside the calves, and on the feet.

On admission he appeared to be a well-nourished healthy man. His face was not expressive of pain or anxiety. There were several superficial sores on the thighs, scrotum, and legs, due to the hot bottles that were applied before admission, and there was a huge shallow bedsore over the sacrum. He was in no pain, but complained of a sense of "deadness" in the lower extremities. There was complete paralysis of both lower limbs, with anæsthesia and loss of reflex excitability, and they were cold from the crests of the ilia downwards. No pulsation could be detected either in the abdomen or in the lower extremities. The heart's apex beat in the sixth interspace four inches and a half below and two inches outside the nipple; its action was heaving, and its sounds (which were free from murmur) were loud and ringing. The radial pulse was large and collapsing. Lungs healthy. There was no abdominal tension or tenderness. He passed his motions unconsciously. Urine alkaline, with a trace of albumen. Had frequent hiccough. During the next few days his general condition underwent little change. His appetite was fair, but he still had hiccough. His paralysis, anæsthesia, and incontinence of urine and fæces continued. But warmth gradually returned to the lower extremities from above downwards, so that by the fourth the only parts which remained actually cold were the toes of the left foot, and pulsation could just be detected in the course of the abdominal aorta. There was no return of pulsation, however, in the lower extremities, and the sacral bedsore was extending. The urine, moreover, continued alkaline, of about 1024 sp. gr., and contained much diffused blood and a quarter albumen, but no visible casts. On the 5th the temperature rose to 100·2°.

On the 6th of April he was still in much the same condition. His legs were fairly warm, but this was due mainly to their being thickly encased in cotton-wool. The toes were cold and cyanotic. His appetite was fair, but he was very thirsty, and still troubled with hiccough. His temperature was normal, his pulse 105, full and throbbing, and its trace much like that of aortic regurgitation. He had passed 46 oz. of urine during the night; smell of slough very offensive.

April 7th.—Slept well under the influence of morphia. This morning complained of pain in the back. Sensation extended to four inches below the iliac crests. Tongue thickly coated; no hiccough. Feet had become livid, more especially toes. A new bedsore had appeared on left buttock. In the afternoon he was for a time strange in manner, and partially unconscious. In the evening his temperature rose to 100·6° F., and his pulse was 132.

8th.—Rational; no particular change; temperature in the morning normal, in the evening 101·4°.

9th.—Complexion cadaverous, face sunken, and offensive odour from body; very drowsy. Has not had hiccough for several days. The sloughs on back, scrotum, and thighs are spreading. The toes are becoming more discoloured, and the left foot is blue and cold. Pulse 120, very weak. The temperature was 98·4° in the morning, and 100·8° in the evening.

10th.—Remained much the same during the earlier part of the day, his temperature being normal. But at 6 10 P.M. he had a rigor, lasting for ten minutes, during which his temperature rose to 102·8°. This was preceded by vomiting, and was followed by profuse sweating. Later in the evening his respirations were 48, his pulse 140.

From this time he gradually sank. He got weaker, and inclined to ramble at times. His pulse was rapid, feeble, and occasionally irregular, and the gangrene of his feet became more pronounced. His temperature went up once or twice to 101°, but it was more frequently normal or subnormal, and just before death it was 96°. He died on the evening of the 14th.

Post-mortem examination, April 15th.—Body emaciated; dry gangrene of toes and other parts of both feet; huge sloughy ulcer over sacral region. Head: Membranes of brain healthy; brain generally healthy, but a largish fairly recent hæmorrhage into left corpus striatum. Chest: Pleuræ and lungs healthy; pericardium healthy; heart enlarged; valves healthy and competent. Abdomen: Liver, spleen, stomach, and bowels healthy. Kidneys: right large, pale, and somewhat translucent; left smaller, but in same condition; both apparently healthy. Bladder much inflamed with tendency to slough. The aorta generally was atheromatous. Behind the heart and just above the diaphragm, at a distance of three inches from the

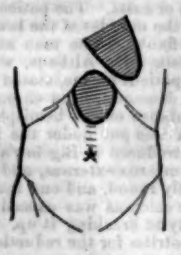
[1] A paper read at the West Surrey District Meeting of the South-Eastern Branch of the British Medical Association, held at Dorking on Thursday, Oct. 21st, 1880.

cœliac axis, was a globular aneurism two inches and a half in circumference, arising from the back of the aorta, and communicating by an oval orifice an inch and a quarter long with that vessel. It had eroded the vertebræ, and was filled with old laminated clot. A second aneurism, as large, perhaps, as a filbert, involved the orifice of the superior mesenteric artery. This also was completely full of clot; and at this point the continuation of the clot into the aorta completely occluded that vessel, so that no water could be forced along it from above, either into the part below or into the superior mesenteric or left renal artery. The aorta between the two aneurisms was irregularly dilated, and three-fourths filled by a tough clot semilunar in transverse section, which was adherent to the posterior and lateral aspects of the vessel, and was continued into the clot which below obstructed the aorta. A somewhat sinuous channel remained in front leading from the aorta above the first aneurism to the cœliac axis and right renal artery, of which vessels the former was quite free, the latter was slightly obstructed. The trunk of the superior mesenteric was filled with adherent clot. The aorta below the superior mesenteric was empty and fairly healthy.

CASE 2. *Aneurism of aorta on level of cœliac axis and superior mesenteric arteries; complete aortic obstruction; partial paraplegia; suppression of urine, followed by albuminuria; congestion of kidneys and bladder; inflammation of rectum; death.*—B. D——, a policeman, thirty-two years of age, was admitted under my care on June 5th, 1880, at 8.40 P.M. He had enjoyed good health, with the exception that two years ago he had some pain in the lower part of the left side of the chest, which was supposed to be pleuritic. It lasted only a short time, and did not confine him to the house. He had never been subjected to ill-usage. On the morning of the day of admission he went on duty in Palace-yard, Westminster, at 6 A.M., and remained on duty till 10. He was then in his accustomed good health, with the exception that during the morning he had a slight attack of diarrhœa. After this he rowed to Wandsworth and back with a friend, then had dinner, and in the evening went for a walk. When close to the Elephant and Castle Railway Station he had a second sudden and severe impulse to go to stool, attended with a sense of coldness in the legs and flushing of the face. He ran up the stairs at the station to the closet, but he had some difficulty in doing this, for his legs were weak, and he was compelled to help himself by taking hold of the balustrade. He had a copious stool; but when he attempted to rise from the seat he found that he had lost completely the use of his legs, and he believes that he had lost feeling in them also. He called for assistance, and was at once put into a cab, and sent to the hospital.

On admission he complained of great pain at and within the anus. While in the taking-in room he seemed unable to move his legs; but when removed to bed he moved them slightly, and could bend them at the knees by voluntary effort. Sensation was impaired in them, they were cold, and no pulsation could be felt in them. A third of a grain of morphia was injected subcutaneously, soon after which he vomited. His temperature at this time was 97·8°. He had a very restless night, only sleeping for a few minutes at a time. His breathing was not unnatural, except that every now and then it became deep-drawn and sighing. He was sick after everything that was given to him, and complained of great thirst. Occasionally he had a return of pain at the anus, and at those times discharged a little blood, together with a small quantity of fæcal matter. He passed no urine; but at 10 A.M. on the 6th three ounces (all the bladder contained) were removed by the catheter. This had a specific gravity of 1020, contained no albumen, and appeared to be healthy.

I saw him for the first time at 1 o'clock the next day. He was a remarkably well-built, muscular, healthy-looking man. But he was evidently suffering from much anxiety of mind and bodily distress. Especially he complained of frequent severe pain at the anus, a gnawing pain down the muscles of both thighs (mainly the left), and abdominal tenderness. He could move his legs very slightly, and sensation in them was generally impaired. In some parts he could not feel the prick of a pin. But he had recovered both sensation and voluntary power in some degree since admission. The feet were cold, and no pulsation could be felt either in the arteries of the lower extremities or in the abdominal vessels. Neither could any abdominal tumour be felt. The heart's action was regular, 106 in the minute, and its sounds, which were free from murmur, were loud and ringing. The pulse was full and bounding. A well-marked murmur was audible over a limited area in the scrobiculus, and could be traced down to the umbilicus. It commenced with the systole of the heart, but was prolonged into the cardiac diastolic period, with some alteration of character. The respirations were not rapid, and every now and then were of a sighing character. The tongue was clean. The skin perspiring slightly. The temperature, which had been 100·9° about 9 A.M., was now 100·4°.—9 P.M.: Has vomited frequently since the last note, but the bowels have not been moved, nor has he passed any urine. He has had little pain, and is drowsy from the influence of morphia. Has some tenderness over seat of left femoral artery, but not over that of the right. No return of pulsation. Legs less cold to touch; natural in colour. The temperature has fallen to 98·7°.



June 7th.—Not much change. Restless, distressed, but no material pain. Constant sickness, and this morning a little hiccough. Tongue coated. The bowels have not been relieved. He passed a few ounces of urine during the night into the bed, and during the morning about an ounce was drawn off by the catheter. This contained three-quarters albumen, but no blood. There was visible pulsation in the brachials and carotids, but none in either femoral. Pulse 78; respirations 24. The temperature, which was 97·7° in the morning, rose to 99·1° in the evening. The surface temperature of the right thigh was 95·8° and of the left thigh 94·6°.

8th.—10 A.M.: Dozed during the early part of the night, and vomited after everything he took until 6 A.M., when it ceased. At that time his breath began to get short and gasping in character, and he commenced to expectorate a quantity of blood-stained mucus. Has had no return of hiccough. Bowels not open. But he passed six ounces of urine voluntarily into a vessel; this had a specific gravity of 1020, was alkaline, offensive, contained much albumen, and microscopically displayed pus-cells, phosphates, and bacteria; but no blood or casts were seen. At the time this note was taken his pulse was 72; his respirations 36, and somewhat gasping; he had occasional cough, with mucous expectoration; there was much crepitation over the front of both sides of the chest, mainly the right, which was also hyper-resonant; and he had pains in the chest. The legs were not apparently colder than other parts of the body; he could feel fairly well in them, and could move them pretty freely, but the right better than the left.—1 P.M.: Much distressed; great dyspnœa; respirations 48; rattling in the throat; constant hacking cough, with expectoration of frothy, blood-stained, watery fluid; abundant moist crepitation over whole of front of chest; pulse 128; temperature 100°. Has passed three ounces and a half of urine, and a little blood from the bowels. He is very restless, and moves his legs freely.—2.30 P.M.: Face pale and livid; surface cool; temperature 96·8°; respirations rapid and sighing, and expectoration of blood-stained mucus continuous; much crepitation over both lungs; pulse 192, regular, but feeble. Complains much of pain in the rectum, and has passed a little more blood by stool. Quite sensible.

From this time he gradually sank, and died at 5 P.M.

Post-mortem, June 9th.—A well-built, muscular, healthy-looking man. Chest: Pericardium healthy, heart weighing seventeen ounces, uniformly enlarged, otherwise healthy; a little atheroma in thoracic aorta; old pleural adhesions; lungs very œdematous; some patches of broncho-pneumonia. Abdomen: Peritoneum healthy; liver, spleen, stomach, and bowels generally healthy. An aneurism rounded but somewhat lobulated in form, and measuring two inches and three-quarters in diameter, opening from the back of the aorta by an orifice one inch and a half long, the lowest point of which was opposite the cœliac axis. The sac of the aneurism wound round the right side of the aorta so as to project nearly an inch in front of it, and it extended down for about an inch behind so as to intervene between the aorta and the vertebræ. The aneurism was completely full of clot, and the pressure exerted by the part last referred to on the aorta immediately in front had completely flattened and occluded that vessel, so that water could not be forced past the seat of obstruction. The

occluded portion of aorta included the superior mesenteric and both renals, the orifices of which were consequently totally obstructed. Direct communication between the cœliac axis and the heart still existed. The bodies of the adjoining vertebræ were eroded. Veins of rectum dilated, and general inflammation of the mucous membrane. Kidneys very large and much congested. Bladder: Some ecchymoses beneath mucous membrane.

(To be concluded.)

A CASE OF AXILLARY HÆMATOMA.

BY SURGEON-MAJOR K. M'LEOD, A.M., M.D.,
PROFESSOR OF SURGERY, CALCUTTA MEDICAL COLLEGE.

History.—Saroda, a Hindoo male, aged forty-five, was admitted into the first surgeon's ward, Calcutta Medical College Hospital, on the 16th of September, 1880, with a large tumour in his left axilla. Two months before he noticed a small swelling in his left axilla. It was soft, painless, and freely movable. It increased somewhat during the next fifteen days. At this time he made a journey of fourteen miles in a cart, and on his return home he observed that the tumour had somewhat shifted its position. He now consulted Surgeon G. C. Ray, who punctured the wound, and found that it contained blood. Dr. Ray, who persuaded him to come to the hospital for relief, furnished the following note regarding the history of the growth: "He presented himself about six weeks ago with a soft tumour filling up the left axillary space. I at first thought it to be of a fatty nature. It shifted its place in the course of a night to the back, the axillary tumour becoming smaller. This confirmed me in my diagnosis of a migrating fatty tumour. After two days the axillary tumour filled up again suddenly, in the course of a night. It had a soft, fluctuating feel. I then thought it to be a hæmatoma. It got tense, painful, and exerted pressure over the brachial plexus. Application of lead and opium relieved the pain, and the tumour hardened. It gradually got smaller in size, when again there was a sudden increase, and it doubled in size. Exploring with a needle brought only fluid blood. It has got harder since then, and is attended with some burning pain." The patient states that its growth during the last month has been very rapid. No history of injury of any kind can be elicited, and the man states that he has always enjoyed good general health.

Condition on admission.—The patient is a well-developed, stout, healthy-looking man. He has a large soft swelling in the left axilla. The tumour as large as a good-sized cocoa-nut, and occupies the whole of the axillary space, the floor of which is convex and bulged downwards. There is also a distinct bulging of the infra-clavicular and mammary regions, and the swelling extends as far as the axillary border of the scapula down to its inferior angle. The apparent swelling measures about eight inches vertically, and about a foot transversely. It is smooth and evenly globular, and the skin subcutaneous. Areolar tissue and pectoral muscles are freely movable over it. It is less movable deeply, and appears to be wedged in between the scapula and chest wall, and firmly fixed to these parts. There is distinct fluctuation; no pain, œdema, heat, pulsation, or bruit. It cannot be emptied by pressure. There is slight deficiency of sensation in the upper and outer half of the left arm, but no œdema of the extremity, nor impairment of muscular power, and the movements of the shoulder-joint are impeded to no greater extent than the situation and size of the tumour explain. The left brachial and radial pulses are normal. The tumour was explored by a fine trocar and cannula, through which a free flow of dark venous blood, apparently undergoing disorganisation, took place. The swelling was diagnosed to be a tumour containing blood; and as the man's general health was good, and the mass, as far as could be ascertained, distinct and separate from the surrounding parts, its removal was considered feasible and justifiable.

Operation.—On Sept. 19th an operation was performed for the removal of the tumour. The patient was chloroformed, and the removal conducted under strict antiseptic precautions. Measures were adopted, in the first instance, to command the circulation. A loop of six strong catgut threads was carried beneath the axillary vessels and brachial plexus by entering a Wood's hernia needle opposite the inner border of the coracoid process of the scapula, carrying it inwards along the lower border of the first rib, and making it emerge about an inch from the sternal end of the clavicle below that bone. It was ascertained, on depressing the handle of the needle, that the radial pulse was obliterated, the pulsation returning on removal of the pressure. The eye of the needle was threaded with three strong catgut threads, and these were pulled through its track, the six ends being knotted together and passed through the loop, and a pad of antiseptic gauze was placed between the noose thus formed and the skin to prevent nipping. By tightening this noose the radial pulse disappeared, and its management was entrusted to an assistant. An Esmarch's india-rubber cord was placed on the arm to command the venous circulation, and by these means the circulation of the region occupied by the tumour was thoroughly abolished, except in so far as it might be supplied by anastomosis from the pectoral and scapular regions. A long horizontal incision was now made along the lower border of the pectoralis major muscle, and another at right angles to it from its middle to the inferior angle of the scapula across the floor of the axilla. The surface of the tumour was thus exposed, and it was found to present a bluish colour, and to be capable of easy separation by the fingers from the surrounding muscles and fasciæ. The mass was in this manner enucleated as far as possible. In endeavouring to separate it posteriorly the finger broke through the cyst wall and a flood of venous hæmorrhage—the contents of the sac—was the result. The deep attachments of the tumour were now caught, tied firmly with stout catgut, and then divided. After the strongest and deepest of these, springing from the inner side of the apex of the axillary cavity, had been thus dealt with, it was found that the axillary vein had undergone division, and a catgut ligature was placed on its proximal and distal orifice. The subscapular vein also required a ligature. The tumour having been removed in this manner, except a small portion of the cyst wall in the angle between the subscapularis and serratus magnus muscles, which was scraped and left behind, the loop and india-rubber band were loosened and several bleeding points removed. The hæmorrhage from these was inconsiderable. The catgut loop was pulled from within the wound and left *in situ* to provide against possible secondary hæmorrhage. The ends of the ligature were utilised for drainage. Two fenestrated caoutchouc tubes were placed in the wound, the edges of which were accurately brought into apposition by iron wire and horsehair sutures. The wound was carefully dressed antiseptically. It was found that a thorough dissection of the axillary space had been made.

Progress and result.—There was considerable shock for several hours, succeeded by reaction, which gradually subsided. The temperature reached a maximum of 101° on the evening of the 20th, and became normal on the 24th. The wound healed by the first intention, except when the drainage-tubes and threads emerged. The tubes were removed on the 21st, the catgut loop on the 22nd, the catgut drain came away on the 27th and 28th, and the stitches were taken away on the same days. The discharge which came from the interior angle of the wound was found to be offensive on the 21st, and continued so for a few days. This seemed to be due to the sulphur in the tubes, for the rest of the wound remained sweet, and the whole of it underwent physiological repair in the same manner as wounds do under antiseptic treatment. Inflammation was absent throughout, and no pus appeared, except from one of the orifices of the loop, where the tissues had been nipped, and at the inner angle of the horizontal wound, where the knot of one of the ligatures caused irritation, and finally came away. The angles of the wound were firmly cicatrised on Oct. 20th, and the patient left hospital on the 22nd, with a thoroughly sound cicatrix. The axillary hollow was deeper than on the opposite side, and the movements of the shoulder somewhat constrained by the cicatricial contraction in the wound cavity. The left pulse was equal to the right. The innervation of the extremity was normal, and no œdema existed. The man's general health was thoroughly sound.

Description of the tumour.—The following description of the tumour, extracted from the museum catalogue, was written by Dr. J. F. P. McConnell, Professor of Pathology and Curator of the museum:—

"*Venous aneurismal sac removed from a Hindoo male, Saroda, aged forty-five.*—This sac or cyst is about the size of a fœtal head. A small portion of it was cut away during

the operation (the rent has now been stitched), and at one part is a rounded opening capable of admitting the little finger, which is the orifice of communication of the sac with the axillary vein; the latter was above and below this spot on the separation of the tumour. The cyst contained only fluid blood—no coagula. On examining the interior there is found a layer of reddish grumous soft material, two to three lines in thickness, unequally distributed over the cyst wall; this material is easily scraped away, and consists of blood coagulum, showing no lamination or decolorisation, and presenting under the microscope only altered blood-corpuscles (broken up and shrivelled), with much dark amorphous pigment matter and some hæmatoidin crystals. When this material is scraped away, the inner surface of the sac or cyst is seen to be smooth and shining—i.e., has a distinct lining membrane, the flattened tesselated and nucleated epithelial cells composing which can quite readily be recognised under the microscope. The rest of the cyst wall consists of well-formed fibro-elastic tissue, with also smooth muscular tissue—in fact, it seems quite identical with the ordinary structure of the walls of a vein; so that there can be no doubt that the sac was an aneurismal-like expansion from the axillary vein, and is not an adventitiously formed cyst. There are no dissepiments or indications of such in the interior of the sac."

Remarks.—The ascertained history does not throw much light on the origin of this remarkable growth. The result of examination after removal points to its being a sacculated venous aneurism, springing and developing primarily from the axillary vein, and not a cyst, serous or angiomatous, which had somehow contracted a secondary communication with the veins. Assuming it to have been caused by a sacculated expansion of the vein, it must have existed in the axilla long before it was noticed. Its existence was probably discovered only when from its size the tumour began to bulge and press uncomfortably on the surrounding parts. Similar tumours are alluded to in the works of Paget and Billroth, but they appear to be rare, and their etiology is undoubtedly obscure. The present case deserves record on account of (1) the size which the cyst attained; (2) the evidence which is afforded of the nature of the growth, which appears to have been a venous aneurism; (3) the expedient which was adopted to prevent hæmorrhage; and (4) the successful removal of so large a tumour from so important a locality with so little disturbance, constitutional or local. This result I am inclined to attribute to the employment of antiseptic precautions (Listerism); and I venture to assert that so easy and complete a cure could not have been obtained in any other way.

Calcutta.

EXCISION OF THE WHOLE TONGUE BY THE GALVANIC ÉCRASEUR.

By F. A. PURCELL, M.D.,
SURGEON TO THE CANCER HOSPITAL, BROMPTON.

IN THE LANCET for July 5th, 1879, I described the operation "for the painless and bloodless method of excising the whole tongue," affected with epithelial cancer. I need not go over the same ground again, but suffice it to say that I have had no reason to deviate in the slightest degree from the operation I there described; I have performed it several times since successfully, but it may be interesting to record a case in which a fatal result has taken place.

On Oct. 12th T. C——, aged thirty-eight, suffering from epithelioma of the entire right side of the tongue, ulcerated, with ichthyosis extending into the opposite side. Glands only slightly enlarged in the submaxillary region. It was decided to remove the entire tongue by the galvanic écraseur. The patient being put under the influence of the anæsthetic I introduced the nozzle of the cannula through a vertical submental incision (after Nunneley) into the floor of the mouth, and, proceeding exactly as I have previously described the operation in THE LANCET of July 5th, 1879, excised the whole tongue, having got well behind the disease. The patient came to without losing during the operation any blood. The submental incision was brought together by one horsehair suture, and he was removed to his bed. Within two days he was up and about the ward, and on October 19th I examined his mouth and found the root and floor of the mouth beginning to show granulations and the slough detaching itself; all seemed well; however, during our operations, the house-surgeon was requested to see him, as he had some hæmorrhage (now eight days after operation). He went to him, and applied some ice and iron solution, which seemed to restrain it. Hæmorrhage again recurred about eight o'clock. The amount was so profuse that our house-surgeon, Dr. Bourns, thought it wise to send for me. I arrived and found my patient very exhausted, with a very feeble pulse, and a clot of blood, blackened from the solution of perchloride of iron that had been applied, hanging out of his mouth, conscious and able to write his wishes and requirements on a slate. Although hæmorrhage seemed to have ceased, I thought it wise to ask for a consultation of my colleagues, who all arrived at the hospital about 11 o'clock P.M. We still found him in the same condition as before described. The advisability of tying the linguals, which should have been done on both sides, was deferred, and instructions to leave the clot *in statu quo*, and feed the patient by enemata of beef-tea and milk, with a half-drachm of tincture of opium every second hour, as also to exercise digital pressure on the carotid of one side first if any hæmorrhage should again appear, and if this did not stop it to try the same on the carotid of the other side. Fortunately the patient passed the night without the recurrence of the bleeding. During the next few days the mouth was left untouched, and the same enemata assiduously continued.

On the 22nd the mouth was cleansed, and he took some iced drinks, much to his relief, cold tea, and nourishing drinks; the tincture of opium was not discontinued. On reflecting light by means of a looking-glass into his mouth, the slough is observed to be detached, and the red granulations appearing. He talks now fairly well, but cautioned not to do so. His pulse has regained its beat; in fact, his heart, which has a systolic murmur with violent palpitation, troubles him much, so that he is ordered a mixture of solution of perchloride of iron and tincture of digitalis every four hours, cold drinks and nourishing enemata every four hours. All seemed favourable towards recovery.

On the 23rd the patient, having discontinued the laudanum in the enemata, did not sleep so well during the night, but otherwise much improved. Diarrhœa set in during the afternoon.

Oct. 24th.—The patient now refuses his food, and is troubled with violent palpitation of the heart, the floor of the mouth granulating nicely, and looks clean. He remained in this condition until he died on Tuesday night, the 26th of October, fourteen days after the operation. He suffered from an aortic and mitral murmur, with a very rapid small pulse. At the same time the heart palpitated violently.

The heart alone was removed after death, and showed great hypertrophy and dilatation of the left ventricle, with incompetent aortic and mitral valves.

Manchester-square, W.

RUPTURED SPLEEN FROM A FALL.

By HENRY TOMKINS, M.D.,
MEDICAL OFFICER, MONSALL FEVER HOSPITAL, MANCHESTER.

RUPTURE of the spleen, though not of very uncommon occurrence, is yet sufficiently rare to warrant the following case being placed upon record, the more so as it presents one or two features peculiar to itself—firstly, the fatal issue did not take place until three weeks after the receipt of the injury; and, secondly, so little importance was attached to the injury that at the time of death suspicion was aroused that the patient had died from the effects of medicine obtained from an unqualified practitioner.

On Oct. 21st, by order of the coroner, a post-mortem examination was made on the body of Mary M——, aged twenty-five, unmarried, who had been found dead in bed ten hours previously. The body was fairly nourished; no external marks of violence, but very anæmic; lips, conjunctiva, &c., quite bloodless. The abdomen was somewhat distended; dull on percussion. On opening it the peritoneal cavity was found filled with dark sanious fluid and numerous large soft clots. Beneath the edge of the ribs on the left side, extending across the epigastrium, was a huge dark mass, which proved to be the spleen. In size, speaking roughly, it was as large as the liver, and weighed at

least four pounds, probably more. On the under-surface the organ was ruptured, and on cutting into it, it was found to be hollowed out into a large cyst filled with soft coagula. All the other organs of the body were healthy and bloodless.

The history given was this:—Three weeks before she had been standing on a box some three feet high, from which she fell, striking her left side against a corner of it. She complained at the time of having hurt herself, but not severely, and in a few minutes after resumed her work. From that time onward she complained more or less of her side, saying it "caught her breath," and that she felt as if she had "a lump there," but her friends could detect nothing abnormal by sight or touch. There was no bruising after the fall.

The night before she died she complained still more of the pain, referring it chiefly to the epigastrium, and called that evening on an unqualified practitioner, who gave her some medicine, of which she took about an ounce and a half, went to bed, and was there found dead the following morning.

At the inquest the medicine was proved to be only a simple antispasmodic mixture.

The blood was unfortunately not examined, so that it is somewhat uncertain whether this was a case of leucæmia; no glandular enlargement was detected, and the previous history pointed to good health, but impoverished circumstances, and shortness of food. If the spleen were normal in size at the time of the accident, the above is certainly a very unusual case. The length of time also that elapsed between the receipt of the injury and the fatal termination is much longer than any I can find recorded.

Manchester.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

GREAT NORTHERN HOSPITAL.

A CASE OF TELANGIECTASIS.

(Under the care of Mr. GAY.)

A VERY remarkable case of this disease was admitted during the last summer. The patient was a girl eight years old, otherwise healthy. The disease was an entirely new growth, and consisted of a cluster of distended veins so convoluted and coiled on each other as to form a compact venous tumour. It occupied the whole of the right side of the cheek, and seemed to be a teratological development of the venous at the expense of the muscular elements, especially that of the buccinator muscle; for before the growth of the tumour the muscular tissue receded and disappeared; so that the tumour bulged outwards on the cheek very considerably, showing its blue colour in patches through the skin, which was extremely thin. On the inner side of the cheek it also bulged as a closely packed mass of large convoluted veins, which at length protruded so far as to incommode the child in talking and masticating by getting between the teeth. From the cheek the growth extended in a broad and irregular band across the back of the mouth and the hard palate, the mucous membrane of the entire half of which was thickened and discoloured by it, and to the lower lip, the half of which was also occupied by large veins, which exalted themselves considerably above the normal level. The tumour on the cheek was defined and impressible, so that the blood could in great part be expressed from it, but not without leaving behind a considerable amount of dense doughy material, that consisted no doubt of the thickened walls of the veins and their intervening connective tissue; and that the whole was enclosed in some tough limiting envelope there could be no doubt, for on expressing the contents and instantly relaxing the pressure, the blood rapidly distended the mass again, but the latter did not exceed its ordinary limits.

The mother could give no trustworthy history of the tumour, but it was unquestionably of congenital origin, and allied to the ordinary nævi of this class. It seemed to have the ordinary supply of nerves and arteries, for its sensibility and temperature were normal, and none but the usual arteries or veins could be found in any part of the healthy bordering structures. The mass was growing but had not bled spontaneously.

After discussing several plans of treatment, and notwithstanding the fact that cauterisation by red-hot needles had been tried elsewhere without any appreciable result of any kind, Mr. Gay determined to cauterise by means of large blunt needles made red hot by benzine vapour.

The child having been placed under the influence of chloroform by Mr. Eastes, the portion of the cheek containing the tumour was thrust out of the mouth as far as possible. The mass having been in this way fairly exposed, Mr. Gay pushed a thick red-hot needle, a line in breadth, deep into the tumour at several points. The blood was not squeezed out of the mass before the needle was used because it was feared that though the cautery would seal the openings in the vessels the needle had made, the reflux of the blood would reopen them, and bleeding would ensue. No bleeding took place, although the openings were as large as a six- or seven-sized catheter. The whole tumour immediately swelled, but subsided again after the escape of a quantity of bloody muco-serous fluid from the burnt aperture and mucous membrane. The results, however, were not satisfactory, for after the healing of the wounds the tumour was left much as it was before the operation. After an interval of three weeks Mr. Gay determined on repeating the cauterisation, but confining the punctures to a limited portion of the swelling. He therefore selected the most vascular portion, and made five punctures within an area of about three-fourths of an inch square. On withdrawing the needle two of these punctures bled copiously, throwing out jets of dark with some crimson blood of the same size as the orifices. The bleeding was, after trying several futile plans, ultimately stopped by passing ligatures deep into the tissue below the bleeding parts, by means of an eyed tenaculum, armed with thick silk, and tying them across the apertures. This procedure was followed by consolidation of the whole of the portion of the tumour that had been brought within its scope, but beyond this the tumour was as active as before. It then became clear that complete obliteration of the mass could only be gained by a series of similar procedures, each being limited to a small portion only of the diseased mass. A portion was now selected full of large vessels nearer the back of the mouth, between the cheek and the palate, and three punctures were made in it. Again the bleeding was very profuse, and as there was some difficulty in using ligatures Mr. Cripps suggested that the openings should be forcibly plugged with lint moistened with the solution of perchloride of iron. In this way the bleeding was stopped, the plugs being allowed to remain until released of themselves. Suffice it to add that the united portion of tissue that was thus brought under the influence of the cautery solidified, but no more, and that it required several other like operations to bring the whole into a like condition. The portion that passed across from the cheek to the palate was exceedingly troublesome, and required several applications of the cautery, each of which was followed by profuse hæmorrhage. Eventually, however, every portion seemed to have succumbed, and the vascular tissue was reduced to a consolidated mass, first of clot and vessels, and ultimately of compact nævoid tissue, minus its blood. Such was the vital tenacity of the growth that the large outlying veins on the lip had to be ligatured in order to bring about their consolidation.

The child presented herself at the hospital a week ago. By far the largest portion had consolidated, but not the whole. There was an island just within the mouth, and another at the extreme back part of the cheek, which presented not only large venous coils, but were in a state of growth. These will require at no distant period the renewed use of the cautery. Mr. Gay prefers the cautery to other modes of treating these nævoid tumours, but he would feel little hesitation in the event of such treatment being unsuitable in a given case to extirpate it by the ordinary knife, or, if found necessary, by red-hot knife, for the supplying artery as well as the receiving veins did not appear to be of abnormal distribution or size.

CLAYTON HOSPITAL, WAKEFIELD.

CASE OF GLOSSITIS.

(Under the care of Mr. FOWLER.)

FOR the following notes we are indebted to Mr. R. L. Williamson.

William H——, aged thirty, was admitted on July 17th with glossitis. The tongue was protruded two and a half inches beyond the teeth, and could not be retracted. The whole organ was very greatly enlarged and of a brawny hardness, due to exudation. A deep ulcerated fissure existed where the tongue rested on the lower incisors. There was difficult, hurried respiration, the breath was fetid, and saliva constantly dribbled from the mouth. Only fluids could be swallowed, and these with difficulty. The dorsum of the protruded portion of the tongue was parched. The patient said the affection began twenty-eight days before, that he was nearly suffocated at first, and that an abscess had formed at the root of the tongue, and burst with only slight relief of the symptoms a week from the commencement of the attack. On admission the temperature was 101° F.

The mouth and all its contents were thoroughly cleansed with a strong solution of chlorate of potash in glycerine and warm water, and a piece of lint frequently wetted with water was kept over the protruded part of the tongue. The mouth was frequently syringed out. No perceptible improvement followed. Four days after admission a gutta-percha support was made for the tongue, and fitted to the lower incisors. This afforded great relief to the patient, and the exudation began to disappear rapidly, so that forty-eight hours afterwards he could retract the tongue within the teeth, after being unable to do so for more than a month. The fissure caused by the pressure of the lower incisors simultaneously disappeared. The patient shortly afterwards could keep the tongue within the teeth permanently, and the case progressed so rapidly that a week from the time the gutta-percha support was first used he was almost well. He was discharged cured seventeen days after admission.

He had not had syphilis nor had he the characteristic signs of scrofula, though this affection, accompanied by abscess, generally occurs in scrofulous subjects. The case is unusual in that the exudation did not tend to disappear after the evacuation of the abscess. It would seem that this persistence of the exudation was due to hyperæmia of the organ, caused mechanically by the pressure of the teeth.

ROSS COTTAGE HOSPITAL.

LOOSE CARTILAGE IN KNEE-JOINT; REMOVAL.

(Under the care of Dr. C. C. COCKS.)

H. G——, aged forty-two, was admitted on Sept. 1st, complaining of pain in his right knee-joint, which had troubled him at times for twelve or eighteen months. On examination a loose cartilage was easily felt. Removal of the body was advised.

On Sept. 2nd, chloroform having been given, and with strict Listerian antiseptic precautions, an opening was made on the outside of the knee-joint, about an inch and a half long, through which a loose cartilage, weighing three drachms and a half, was easily removed.

The patient made an uninterrupted recovery, and was up on the twenty-first day, and at the end of eight weeks followed his work as a labourer.

After removal the substance was examined, and found to be made up of an oblong flat piece of bone-like material, with a thick corrugated fringe of cartilage all round.

LINCOLN COUNTY HOSPITAL.—The annual meeting of the Board of Governors of this institution was held on the 13th inst. The financial statement showed the receipts during the past year to be £4295 4*s.* 1*d.*, and the expenditure £5565 1*s.* 7*d.* Various propositions were made to remedy this unsatisfactory state of things, but ultimately it was decided to issue a special appeal to well-to-do persons in the neighbourhood who were not already subscribers — a step which we hope may meet with the success desired.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Acute Myositis.—Abscess of Liver.—Cirrhosis of Liver and Tuberculosis.—Thrombosis of Innominate Vein.—Stenosis of Tricuspid Orifice.—Fibro-cyst of Uterus.

THE ordinary meeting of the Pathological Society of London was held on Tuesday last, Dr. Wilks, the newly-elected President, in the chair. There was a very small attendance of members. On the motion of Dr. Pye-Smith, seconded by Mr. Morrant Baker, the President was requested to postpone his introductory address until the next meeting, as there were many members of the Society anxious to hear it who were prevented from being present by the extremely inclement weather. Dr. Wilks consented to this proposal, and the ordinary business of the Society was proceeded with. In addition to other communications of interest, Dr. Fenwick made a careful and valuable communication on Stenosis of the Tricuspid Orifice of the Heart.

Dr. PAYNE showed a specimen of Acute Myositis, and read an account of it, sent to Dr. Greenfield by Dr. Bevis, of the Hereford Infirmary. A woman, aged thirty-three, three days after her confinement got up and went downstairs into a cold room, where she had a shiver, and on attempting to return to bed found she had to crawl on hands and knees, on account of severe pain in the right thigh. The pain increased for the next two days; and on the third day there were tenderness, rapidly increasing swelling, and redness of the skin. She was then admitted to the hospital. She had chills, but no sweats; temperature about 100·4°; pulse 132; tongue dry, with sordes on the lips; no cardiac bruit. The right thigh was much swollen, hard, brawny, very tender, hot, and there was pitting on pressure. Next day the pain was less; there was great tremor, and she died. At the post-mortem the bone and periosteum were healthy. A section of the muscles showed the vasti and crureus to be yellowish in colour, resistant, the fasciculi separated so as to present a granular surface, the fibrous septa being infiltrated with serum. The fibres of the vastus externus were found to have lost their striæ, and to contain granular débris and very few cell elements. The adductor magnus muscle had its striæ well marked, with many cells, and both red and white blood-corpuscles. The rectus femoris was healthy.

Dr. NORMAN MOORE showed a specimen of an Abscess in the Left Lobe of the Liver in a girl, aged three years and a half, who died in St. Bartholomew's Hospital. She had been ill ten months with intermittent diarrhœa and pains in the belly. During her stay in the hospital her temperature varied from 102° to 105°; at the end of a month she died from sudden collapse. After death this abscess at the surface of the left lobe and another larger one in the substance of the right lobe of the liver were found. The whole of the large intestine was extensively ulcerated. The points of interest in the case were the early age of the patient, and the fact that the child had never been out of London; although he had known of dysentery occurring in Londoners, he had not been able to meet with any case occurring in so young a child.

Dr. NORMAN MOORE also showed microscopical sections of a Liver affected with Cirrhosis. A girl ten years of age, under Dr. Gee's care at St. Bartholomew's Hospital, had enlargement of the belly for some time; she was tapped twice for the ascites. At the autopsy the whole liver was found to be dense, with great elastic bands of fibrous tissue running through it, rough and nodular; there was tuberculosis of the peritoneum, but none of the liver. There was no history of spirit-drinking, and Dr. Moore thought this was an example of interstitial hepatitis in association with general tuberculosis, as described by Cornil and Ranvier, and more fully by Dr. Payne.—The PRESIDENT asked if the patient had the usual appearance of patients with cirrhosis of the liver, and whether the diagnosis was made.—Dr. MOORE replied that the child was very emaciated, and with a big belly; after one of the tappings it was noted "liver certainly not enlarged."—Dr. PYE-SMITH had recently a young man under his care at Guy's Hospital with great ascites and no symptoms of any

lung affection; he was tapped two or three times, and eventually died. Slight cirrhosis of the liver, with considerable tuberculosis of the peritoneum and right pleura, were found. The diagnosis was difficult; he had thought the ascites due to cirrhosis of the liver from drink, but now had no doubt it was occasioned by the inflammation of the peritoneum.—The PRESIDENT asked for information on the collateral circulation of the liver. The enlargement of the superficial veins of the belly had been long noticed and variously explained, and he had read that it had been shown by German observers to be connected with enlargement of vessels in the suspensory ligament of the liver, and particularly with reopening of the obliterated umbilical vein. It would be very interesting if any member could demonstrate such a condition, which would be best done by injection from the portal vein. If this be the correct explanation, the blood circulating in the dilated vessels is portal blood, and possibly that could be demonstrated by microscopic examination. There must be a very free collateral circulation in some cases, for with extreme cirrhosis and narrowing of the portal vessels there may be no ascites.—Dr. N. MOORE mentioned the case of a woman who, thirty years ago, had severe hæmatemesis, which was repeated from time to time, until recently during an attack in St. Bartholomew's Hospital she died. There was found complete occlusion of the portal vein, the spleen was greatly enlarged, no ascites; Dr. Gee could not find any opening out of the obliterated umbilical vein, showing that this was not the sole collateral circulation.—Dr. STURGE stated that two years and a half ago he had under his care a man with cirrhosis of the liver, with not very marked ascites, who had a well-marked caput medusæ at his umbilicus, and a vessel as large as his forefinger running upwards from it to the sternum. During life it was doubtful whether the swelling contained blood or serous fluid, but he inclined to the former view. The ascites disappeared, and he saw no more of the man till three months ago, when he heard of his death. He made an examination, and found a vein large enough to admit his little finger passing from the portal vein through the suspensory ligament, a vein in the round ligament as large as a probe, and others intermediate in size between these two around the ligament. All these veins entered the caput medusæ, from which the large veins seen on the surface passed to the internal mammary vein.—Dr. GILBART SMITH had under his care now a man with phthisis affecting the left apex, and irregular enlargement of the liver; there is very little fulness of the abdomen, but the veins passing from the umbilicus to the chest are distinctly enlarged; he thought this was a case of tubercular peritonitis, with cirrhosis of the liver.—Dr. PAYNE thought the case of his that Dr. Moore referred to was one in which many small fibroid nodules were found in a liver, possibly tubercular. He had many times injected the portal vein in cases of cirrhosis, and had sometimes found a vein running up the round ligament, but never the whole way, and many other veins running from the liver to the umbilicus outside the round ligament. This collateral circulation was first described by Sappey. Dr. Champneys had published in the "Journal of Anatomy" a description of a case of reopening of the umbilical vein. There are also many other anastomoses of the portal and systemic veins in the peritoneal cavity.—Dr. O'CONNOR mentioned the case of a woman who, when she lay on her face, had no œdema of the feet, but the superficial veins of the belly became distinct; but when lying on her back the veins were empty, and the legs became œdematous.

Dr. WILBERFORCE SMITH brought forward a specimen of Thrombosis of the Right Innominate Vein. It was removed from a woman forty-two years of age, who had some severe respiratory affection ten years ago, which left her subject to cough. Eight months ago she had a transient attack of dropsy, commencing in the left arm, and two months ago another attack of dropsy, which commenced in the feet. Four weeks later he found she had great swelling of the right arm up to two inches below the shoulder, lividity with enlarged superficial veins of the right side of the head and neck, œdema over the right side of the chest, dulness at the right apex, especially at the inner side. The case had then the appearance of serious cardiac disease, but there was no orthopnœa. At the autopsy several pints of fluid were found in the right pleura. The right innominate vein was occluded by firmly adherent partially organised clot, which extended into the superior vena cava, and the ends of the subclavian and jugular veins were contracted and full of soft clot. The pleura was very thick and adherent to the apex of the lung and to the thrombosed vein. In the apex of the lung was a cavity, but no other disease. In the right side of the dilated heart were two or three smooth old clots the size of orange pips. The order of events he believed to have been—1. Respiratory affection. 2. Dilatation of the heart, and weak circulation. 3. Thrombosis favoured by the languid circulation, and especially by the thickening and adhesion of the adjacent pleura.—Dr. COUPLAND had seen the post-mortem examination in this case, and agreed with Dr. Smith's view. He asked if this form of thrombosis is common; if not he was surprised, as the pleura is so near the veins and so often inflamed. The pleura in this case was very firmly adherent to the vein.—Dr. T. C. WILLIAMS had often seen thrombosis of the lower extremities in phthisis, but seldom, if ever, in the neck.

Dr. FENWICK showed two specimens of Stenosis of the Tricuspid Orifice of the Heart. The first case occurred in a single female-servant, aged twenty-nine, who had very good health till eighteen years of age, when she had an attack of acute rheumatism. Four years afterwards when carrying a very heavy child she was seized with severe pain in the side and great dyspnœa, which passed off under rest. Five years later she entered the London Hospital for jaundice, and was found to have a loud presystolic murmur, most distinct at the apex, and a soft whiff at the base. She had two other attacks of acute rheumatism, and after the last a harsh systolic murmur at the base was detected; and last autumn, when under Dr. S. Fenwick's care at the hospital, there was a harsh presystolic murmur distinctly audible at the xiphoid cartilage, apex thrill, great distension of jugular veins, œdema, and orthopnœa. After death the heart was found greatly dilated, especially the right auricle; the tricuspid valve agglutinated by the edges of the cusps, which were also thickened, and the orifice narrowed; mitral valve also thickened. The other case was also under Dr. S. Fenwick's care: a girl, aged twenty-six, single, enjoyed good health up to the age of twenty-three, then had acute rheumatism and ever afterwards dyspnœa, cough, and palpitation; harsh presystolic murmur at apex, presystolic thrill, tumultuous cardiac action with throbbing of the whole side; soft systolic murmur at base, great orthopnœa, cough, and ascites. The heart was found to be very dilated, especially the right auricle, mitral cusps thickened, rough, and adherent; tricuspid valve agglutinated, with only a very small aperture; pericardium adherent. From a review of forty-six cases of tricuspid stenosis recorded since 1825 he gleaned the following facts: That the disease is not excessively rare, as seven are recorded in the Transactions of the Pathological Society and eight in the Transactions of the Pathological Society of Dublin, and three had recently occurred in Dr. S. Fenwick's practice at the London Hospital. Forty-one of the patients were females to five males—a preference for the female sex not shown by congenital disease of the heart, for of thirty-one of such cases shown to this Society, seventeen were in the male and fourteen in the female sex. The youngest female was seventeen, male twenty-one, oldest female fifty-eight, male sixty-four; average duration of life in the females 31 years, in the males 36·4 years. In Dr. Peacock's case of congenital or tricuspid stenosis, which lived only three months, the child was perfectly livid from birth, and became black on coughing; but in only one of these forty-six cases was dark colouration noticed during early life, and the health was good until the fatal illness came on. Thus there are many facts opposed to the view of the congenital origin of this form of disease. In twenty-three cases there is a history of antecedent acute rheumatism, and such a history was obtained in one hundred and fifty-two out of three hundred and four cases of all cardiac diseases, the same proportion. In all the forty-six cases the mitral orifice is also stenosed, and in nearly all more diseased than the tricuspid; in twenty-five cases the aortic valves are diseased too, in twelve cases stenosis; in all save a very few the right auricle is greatly dilated. He therefore maintained there is positive evidence of its being an acquired disease.—Dr. N. MOORE had found thirteen cases of this disease recorded at St. Bartholomew's Hospital, and they bore out completely Dr. Fenwick's views. Twelve of the patients were females, the youngest nineteen, general age thirty; in all mitral disease; in nine aortic disease; and in one disease of all the other valves. In one only was there any trace of congenital malformation, a partial septum across the right auricle. Thus there was evidence that in these cases the endocarditis was general rather than local, and tended to adhesion rather than outgrowth and pucker-

ing of the valves.—Dr. GILBART SMITH asked if cases of double stenosis live longer than those suffering from mitral stenosis only, because the double obstruction might save the heart and pulmonary circulation and regulate the distribution of the blood.—Dr. HORROCKS observed that in congenital mitral stenosis the left auricle does not hypertrophy sufficiently to overcome the obstruction and so carry on the general nutrition, and the patients look younger than their age. Were any recent vegetations found on the valves in Dr. Fenwick's cases?—Dr. COUPLAND thought the question was as to the etiology of mitral disease, because it was always present in these cases; mitral stenosis is more common in females; in some cases there is no history of acute rheumatism to be elicited. He had found vegetations on the tricuspid valve more common in acute rheumatism than supposed, but never present without being also on mitral valve.—Dr. STURGE recently made an autopsy in which he found two cusps of the aortic valve agglutinated together, all the cusps being uniformly thickened; the mitral valve was in the same condition, and he thought this case supported Dr. Moore's view of their being a special agglutinative form of endocarditis.—The PRESIDENT reminded the Society of some Gulstonian lectures of the late Dr. Barlow, in which he pointed out that disease of the right side of the heart, lessening the blood on the left side, caused imperfect growth on that side, and the mitral orifice remained small. Presystolic murmur over the xiphoid cartilage was taught as the sign of tricuspid obstruction, but he knew of no case on record where by this sign it had been actually diagnosed.—Dr. FENWICK had not observed any marked relation between double stenosis and duration of life. In neither case were there recent vegetations. He had recently seen very numerous vegetations on the tricuspid valve; they were present on the mitral valve also. Both his patients were well nourished and fully grown; in his table two only are mentioned as stunted.

Mr. MEREDITH showed a recent specimen of a large Multilocular Fibro-cyst of the Uterus, removed three days previously by Mr. Thornton from a patient in the Samaritan Hospital, aged forty-three. The existence of uterine fibroid disease had been first recognised ten years ago, but only within the past three years had the tumour, which up to that time had apparently presented the usual features of an ordinary fibroid growth, begun to enlarge at all rapidly. The total weight of the mass removed was twenty-three pounds, of which the fluid contents constituted about eighteen pounds. On examination the main portion of the tumour was seen to have consisted of smooth walled cystic cavities, eight to ten in number, and of varying capacity, seated on a solid base, which sprang from the fundus of a much enlarged uterus, by an extremely thick pedicle, partly fibrous, partly fleshy in structure. This pedicle at the operation was divided by means of Paquelin's blunt cautery knife. The cyst contents in most of the cavities consisted of a perfectly clear limpid fluid, of a deep amber colour, which did not coagulate spontaneously on subsequent exposure. Its sp. gr. was 1020, and on boiling a dense coagulum was formed, which proved to be incompletely soluble on being heated with an equal quantity of strong nitric acid. The microscope showed but few cell elements of any kind; among these were a number of large granular cells, resembling those found in ovarian fluids, a few squamous epithelial cells, and occasional examples of the so-called "fibre-cell," which is said to be characteristic of the fluid contained in these fibro-cysts.

The Society then adjourned.

CLINICAL SOCIETY OF LONDON.

Traumatic Hydronephrosis.—Myxœdema.

THE annual general meeting of this Society was held on the 14th inst., Dr. E. H. Greenhow, F.R.S., President, in the chair. The usual business was transacted during the first part of the evening, after which the election of officers, the reception of the Council's report, and the customary votes of thanks to the retiring officers took place. Two papers were read—one on a case of hydronephrosis of traumatic origin, cured by repeated tapping, by Mr. Croft, and one on two cases of myxœdema, by Dr. Lloyd. The latter paper excited some discussion, Dr. Andrew Clark relating his experience of the affection, which he stated he had met with most frequently in males. Drs. Dowse and Mahomed were appointed scrutineers of the ballot.

Mr. CROFT read a paper on a case of Traumatic Hydronephrosis. The patient, a lad aged twelve, was admitted into St. Thomas's Hospital on June 3rd, suffering from hæmaturia, with pain in the left loin, following an injury to the left side received on the previous day. There was no swelling, but there was deep-seated tenderness in the loin. The urine had a dark port-wine colour from admixture with blood. The boy was delicate and anæmic, and was the subject of psoriasis. Under treatment by rest in bed and the local application of ice, the hæmaturia gradually subsided, and on the fourteenth day from the accident he was discharged as convalescent, no tumour having appeared. On July 9th—twenty-two days after he left the hospital—he was readmitted, suffering from a swelling which had appeared in the left side. The swelling occupied the left lumbar and hypochondriac regions, and extended forwards into the epigastric and umbilical regions. It was fluctuating, but there was no redness of skin over it. The urine was free from blood, and of normal specific gravity. During the next two days he became worse; the swelling increased, extending across the median line, and he became drowsy, the temperature falling below 100°. The urine was still free from blood or albumen, its quantity varying from fourteen to twenty ounces. The case being thought to be one of hydronephrosis, an aspirating trocar was passed into the swelling, and seventy-nine ounces of brown, urinous fluid, acid, sp. gr. 1008, and containing a trace of albumen, were drawn off. During the next three days he passed twenty-five ounces of urine each day, and on the fifth day twenty-one ounces. There was immediate relief after the tapping, but at the end of a week a re-accumulation of fluid necessitated a second tapping; which was repeated for the second time nine days later, when sixty-two ounces of similar fluid, acid, sp. gr. 1005, and containing a trace of albumen, were withdrawn. Between July 29th and October 15th the swelling was tapped five times; and on the last occasion the fluid contained much albumen, since when no further collection has taken place. There had been no constitutional disturbance, and no sudden variation in the quantity of urine passed. Mr. Croft thought that there had been a severe contusion of the pelvis of the kidney, followed by adhesive inflammation and obliteration of the ureter, which led to accumulation of the urine in the pelvis and the formation of the hydronephrosis. The case could not be one of a congenital cyst which had enlarged in consequence of the injury, for such a cyst would contain serous fluid. The cure probably took place by obliteration of the sac and atrophy of the kidney. A similar case is recorded by Mr. Stanley in the Med.-Chir. Trans. for 1844, where six weeks after an injury to the right side a large swelling appeared from which fifty ounces of urinous fluid were drawn off. The tapping was repeated at intervals, only six ounces being withdrawn at the final tapping, and the patient left the hospital at the end of nine months with a fluctuating swelling still present. A second case recorded in the same paper appeared rather to be one of retro-peritoneal extravasation of urine. The present case showed the value of repeated tapping by the aspirator.—Mr. HEATH thought Mr. Croft's explanation hardly accounted for the complete disappearance of the swelling. Might not the hydronephrosis have been due to an impacted calculus? The accident might have shaken a calculus into the pelvis, where it would have caused an obstruction to the outflow of urine, and the repeated tappings might have caused the dislodgment of the calculus. Were there any bladder symptoms, and does the patient now pass a normal quantity of urine?—Mr. CROFT said the idea of calculus had occurred to him, but his inquiries failed to elicit any confirmation of this view. As the tumour subsided he passed a normal quantity of urine. If a calculus had been dislodged there should have been some symptoms of it in the bladder.

Dr. LLOYD read notes of two cases of Myxœdema, one of which was shown to the Society. Case 1.—A female, aged forty, whose mother had been subject to rheumatism. She menstruated regularly. Five years ago she experienced severe pain in both her legs, and then all her movements became slow and deliberate. She also suffered from pain in the head, and her face became puffy. Three years ago she began to complain of weakness in the neck, which was painful; her voice became rougher, her memory impaired, and her expression listless. There seemed to be general

swelling of the skin all over the body, and especially puffiness of the eyelids. The skin, which was dry and rough, never perspiring, had a translucent œdematous appearance; and she came to present the characteristic aspect of the disease in the heavy puffed features, with congested cheeks contrasting with rest of face, which was void of expression. Her voice is thick and nasal. She is low-spirited at the menstrual period, and has had delusions. The urine has contained some albumen, but is now free from it, and of specific gravity 1022. Case 2.—A laundress, aged sixty-five, came under care in 1879, with the signs of myxœdema marked by cardiac disease and ascites, from which she died shortly afterwards. The post-mortem examination showed great swelling of the lower extremities, the skin of the abdomen tense and shining, and the seat of purpuric patches. The superficial vessels of the face were injected. The peritoneal sac contained twelve pints of fluid, and about a pint of effusion occurred in each pleura. The kidneys were cirrhosed; the heart was hypertrophied, mitral and aortic valves thickened. The brain and spinal cord were examined, but showed nothing very distinctive. — Mr. HULKE inquired whether, in the second case, any chemical tests had been applied to distinguish the character of the fluid distending the tissues from the dropsical effusion ordinarily present in a subject of long-standing heart disease?—Dr. ORD had seen both the cases. The first was a well-marked example of myxœdema, exhibiting general swelling of the integument, which was translucent, dry, and inelastic. There was thinness of the hair—usually met with in these cases; and there was the vivid carmine colouration of the cheeks contrasting strikingly with the extremely pale eyelids. When he saw the case there was no œdematous pitting at any part. She also had the characteristic slowness of speech. The urine contained a slight quantity of albumen, but was not otherwise altered. He asked if Dr. Lloyd could give any information as to the temperature, which is nearly always subnormal. Her gait was characteristic, walking slowly with a tendency to trip, and to give way especially at the knees. The second case was, when he saw it, in the last stage; and after a time these cases lose their characteristic swelling, so that the skin becomes wrinkled and movable; and fresh symptoms, cerebral or renal, supervene and predominate. This patient had manifestly damaged kidneys, cardiac hypertrophy, and much ascites. Dr. Ord was still engaged in examining the tissues of this case, especially the spinal cord, for the nervous symptoms of the disease pointed either to altered relations with the exterior from impairment of the peripheral nerves or to changes in the nerve centres themselves. At first he had thought that the change in the skin was sufficient to account for the impaired activity of the nervous system, and in the first case he had examined no lesions were found either in the brain or cord. In the present case, however, there was general increase in the connective tissue of the cord, especially around the vessels and the central canal; but he had not found any evidence of destruction or degeneration of the nerve elements. — The PRESIDENT hoped that Dr. Ord's report would be added to Dr. Lloyd's paper, and at the former's suggestion Dr. Savage was asked to draw up the report in conjunction with Dr. Ord.—Dr. ANDREW CLARK said that for the past ten years he had been more or less familiar with this class of cases, which had been principally brought into notice by Drs. Ord and Duckworth; and with Dr. Burnet's assistance he had been engaged in collecting these cases—in none of which, however, had he obtained a post-mortem examination. His experience of them agreed with Dr. Ord's descriptions, except that he had seen the affection far more often in males than in females. They had a striking resemblance to one another; they speak in the same way, move in the same way, act in the same way. Their well-marked characteristics consisted in the white, dry skin, pink cheeks, broad lips, swollen eyelids, and puffy hands; and they complain of being "bound," as if the muscles of the limbs, and sometimes of the face, were hindered from acting. The urine was of low density, nearly always below 1014. As to nervous symptoms, the majority are noticed to be dull, to have a certain hebetude, and to speak with peculiar deliberation and nasal intonation; the voice in males being low-pitched and rough; in females it reaches falsetto. The last common characteristic is that they nearly all have exhibited nervous symptoms resembling the early stages of ataxy; many are unable to walk in the dark, and many cannot stand with their feet close together. The first impression he had of the nature of these cases was that the disease commenced in the nervous system, then attacked the kidney, producing "renal inadequacy," so that these organs became incapable of excreting a healthy urine, and that subsequently the blood was affected. He proposed shortly to bring these cases before the Society.—Dr. ORD said that in four cases in which the urine had been daily analysed, the quantity of urea was found to be much below the average.—The PRESIDENT had seen cases, but did not understand their nature until Dr. Ord elucidated it. One case was undoubtedly combined with sclerosis of the nerve-centres, and another, which was under his care fourteen or fifteen years ago, was, he believed, the same as that brought before the Society lately by Dr. Duckworth.—Dr. LLOYD, in reply, said the temperature in his case never exceeded 96° or 97°; once it was only 94°.

The business of the annual general meeting was then proceeded with, after which the Society adjourned.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Hyposcleral Cyclotomy.—Rare Form of Muscular Asthenopia.—Ophthalmoplegia Interna.—Detachment of Retina.—Tumour involving Optic Chiasma.—Epithelioma of Orbit.

AT the meeting of this Society, held on the 13th inst., W. Bowman, Esq., F.R.S., in the chair, several communications were read, that which gave rise to most discussion being a paper by Mr. Hulke criticising Mr. Hutchinson's hypothesis that cases of total immobility of the pupil combined with loss of accommodation was due to disease of the lenticular ganglia. Mr. Hulke suggested the ganglionic plexuses in the choroid and iris as the probable seat of disease, whereas Dr. Gowers suggested that in these cases there was affection of the centres themselves.

Mr. HIGGENS read a paper on Hyposcleral Cyclotomy, in which reference was made to Mr. J. E. Walker's "Essays on Ophthalmology," where this operation is described and its results in several cases given. The expectation raised by perusal of the essays in question were scarcely realised. Seven cases were reported by Mr. Higgens, and the experience of these cases led him to believe that hyposcleral cyclotomy as a means of reducing ocular tension is inferior to iridectomy.—Mr. WALKER, replying to the criticisms passed on the operation, stated that in acute glaucoma its superiority over iridectomy was marked, and in chronic glaucoma it often gave a good result. It was founded on the view that the tension in glaucoma was due to changes in the ciliary muscle, and that the habitual strain of this muscle in hypermetropic eyes predisposed them to the disease. This hypothesis seemed to him confirmed when he noticed that in certain cases of astigmatism the ciliary muscle appeared to act unequally, an occurrence which seemed to harmonise with Dr. Brailey's observations on partial sclerosis and atrophy of the ciliary muscle in glaucomatous eyes. The success of iridectomy or sclerotomy in glaucoma depended on the escape of fluid through a scleral fistula; but by division of the ciliary muscle only in cyclotomy the tension was remedied without this taking place. He hoped that Mr. Higgens would not abandon the operation, but give it a fair trial. At the request of Mr. Spencer Watson, he briefly described the method of operating.

Dr. BRAILEY read a paper "On a Rare Form of Muscular Asthenopia," describing a case in which with normal power of both internal and external recti, and with very abundant accommodative power, though unaccompanied by spasm, there was great irritation, with pain, on any use of the eyes. The patient, a very intelligent gentleman, aged thirty, had a low degree of myopia, with a little myopic astigmatism. When, however, these were fully corrected, the symptoms of asthenopia were even more pronounced than before; nor did correction of the astigmatism by cylinders alone give any material benefit, though when these were for near work, combined with weak convex sphericals, he obtained some temporary relief. But a permanent and far greater beneficial effect was produced when a prism, apex downwards, before the left eye was added to the cylinders. He has worn this combination during several hours daily for many months, and its beneficial effect still continues. With its

discontinuance the symptoms return.—In reply to Mr. Nettleship, Dr. Brailey said that since using the glasses the patient had worked more than before. In fact, he had been almost compelled to abandon his pursuits prior to treatment; and in reply to the President he said that the affection was of many years' standing.—Mr. COUPER said that he had found it useful in muscular asthenopia to employ prisms for a certain time each day to force the weaker muscles into play, instead of in the opposite direction, for the purpose of relieving the affected muscles. In cases of weakness of the internal rectus he had found great benefit from thus using gradually stronger and stronger prisms.

Mr. HULKE read a paper "On Ophthalmoplegia Interna" (paralysis of the ciliary muscle, and of both the circular and radiating fibres of the iris), which he stated is not pathognomic of disease of the lenticular ganglion, but is with great probability referable to disease of the ganglionic plexuses within the eyeball in immediate relation with the intraocular muscular apparatus. The hypothesis that these symptoms are caused by disease of the lenticular ganglion rests on the assumption that the iris and ciliary body receive all their nerves through the lenticular ganglion. This assumption can no longer be maintained, since (1) it has been experimentally proved in dogs and rabbits that after removal of this ganglion the radiating (dilating) muscular fibres of the iris still contract if the sympathetic in the neck be stimulated, and (2) pupillary dilating nerve-fibres have been proved to accompany the first division of the fifth nerve, and to reach the eyeball without traversing the lenticular ganglia. Ganglion cells were shown to be present in the choroid and ciliary body many years ago by Schweigger and the author, and their presence has since been verified. It is suggested that they may be immediately concerned in the movements of accommodation and pupil.—Mr. HUTCHINSON was indebted to Mr. Hulke for the criticism of his paper, written two years ago, recording four or five cases of a very rare condition, in which the iris remained incapable of dilatation or contraction, combined with paralysis of accommodation, but no paralysis of the external muscles of the eye. But he was disappointed at the scope of Mr. Hulke's paper, which dealt only with certain familiar points in anatomy and physiology, for he hoped that Mr. Hulke would have produced facts upon the affection from his great fund of clinical experience. He held, however, in the main to the belief stated in his paper, which he had carefully considered before publishing; and he had not overlooked the fact that the parts involved received other sources of sympathetic supply than by way of the lenticular ganglia. He would have been glad if Mr. Hulke could have shown that the ganglionic plexuses were the seat of disease, for such a fact would have lent great support to a point of speculative pathology upon which he had dwelt in his lectures at the College of Surgeons—viz., that "trophic" changes were due to the association of vaso-motor fibres with sensory nerves, and not to any special trophic influence in certain sensory nerve fibres. Although the view sketched by Mr. Hulke was probable, yet was it not less probable than that which he had suggested—viz., that the conditions were due to disease of the lenticular ganglion. The fact that experiments showed that the pupil would dilate under atropine, or stimulation of the cervical sympathetic after extirpation of this ganglion, did not disprove his hypothesis. It is quite likely that galvanism of the sympathetic, could it have been practised, would have influenced the pupil in the cases he had described. What would be the symptoms of disease of the lenticular ganglion if not such as these? Neither hypothesis had been proved; but it was at least improbable that the disease should involve so large an extent of surface as must be the case if Mr. Hulke's theory be correct; and it would be more likely that it should involve so compact a body as the lenticular ganglion. That atropin and eserin act on the pupil after removal of this ganglion was rather in favour of his own view, for they so acted in his cases; and it might be doubted if they would cause any effect were the peripheral nerves involved. He did not mean by ophthalmoplegia interna that the pupil does not respond to any influence. The subject was one of great interest, and possibly there might be other causes at work—e.g., disease of the nerve-centre; for one of his cases was associated with locomotor ataxy. But he maintained that his own interpretation was more consistent with the facts of the affection than Mr. Hulke's.—Dr. GOWERS interpreted Mr. Hulke's theory to be that degeneration of the ganglionic cells destroyed the mechanism by which reflex action works. Each theory supplied an adequate explanation of the phenomena. Stimulation of the sympathetic might possibly afford some means of distinguishing the true seat of disease; for in that case no effect should follow were the ganglionic cells diseased (as the sympathetic fibres do not pass through the lenticular ganglion). But if the ganglion were diseased slow dilatation of the iris should persist in stimulation of the sympathetic. And in man such excitation of the sympathetic could be effected by simply stimulating the sensory fibres. But both these theories failed in having any direct or indirect proof. The evidence was much greater in favour of central disease. In the floor of the third ventricle there were a series of nuclei close together, influencing respectively accommodation, the pupil, and the muscles of the eyeball; and they were so far distinct as to be capable of separate stimulation, and from disease of each might arise (1) ophthalmoplegia externa, (2) loss of reflex action of pupil to light, (3) loss of accommodation. Loss of reflex action of the pupil to light is very frequent in locomotor ataxy; and also in syphilitic subjects without ataxy, which had been mentioned by Erb, and Dr. Gowers had seen three cases. Ophthalmoplegia externa occurs occasionally in constitutional syphilis. Ophthalmoplegia interna was met with by Mr. Hutchinson, associated with ataxy in one case, and with syphilis in all his cases. There could hardly be loss of reflex action of the pupil, except from central disease. He thought it then very probable that ophthalmoplegia interna was due to disease in the situation of the nuclei. The selection of so limited an area by a lesion was not more surprising than occurred in other diseases of the nervous system—e.g., locomotor ataxy, or labio-glosso-pharyngeal paralysis.—Mr. HULKE, in reply, said that so far as he could judge of the matter, he still held that if—in the absence of the lenticular ganglion—the movements of the pupil still remained unaffected, and the mechanism of accommodation uninjured, there was no proof that the condition in which these actions were destroyed was due to disease of that ganglion.

Dr. DAVIDSON exhibited a specimen and drawings of Detachment of the Retina in a case of Bright's disease. The patient was admitted into hospital with right hemiplegia and aphasia a day after an apoplectic seizure. The urine contained albumen, and there was a systolic bruit at the heart's apex. There was complete paralysis of the right external rectus, and severe neuro-retinitis, with hæmorrhages. Blindness gradually supervened, and detachment of the retina was discovered. Death took place about seven weeks after admission, and, in addition to cerebral hæmorrhage, the kidneys were found to be granular, the right extensively atrophied, and the left ventricle of the heart hypertrophied.

Dr. FITZGERALD (of Dublin) communicated a case and drawing also of Retinal Detachment in Bright's disease. The patient was a female, admitted with much dropsy, under the care of Dr. F. B. Quinlan, and renal albuminuria. There was considerable impairment of sight of the left eye, where, in addition to albuminuric retinitis, there was an extensive detachment of the retina. She died from uræmia nine days after admission, and the kidneys were found to be of the large white form.

Mr. MCHARDY exhibited a specimen of a Tumour involving the Optic Chiasma, from a woman thirty-five years old, who had been ill for seven months and had complained of failing vision for three months. At the same time she suffered from pain in the head, and especially in the occipital region, with deafness and a gait suggestive of cerebellar disease. There was also great thirst. Vision was much impaired, and examination showed appearances of white atrophy of both discs, but no evidence of neuritis. After death the optic commissure was found to be involved in an irregular tumour lodged between the crura cerebri, extending in front to the longitudinal fissure and involving the root of the right olfactory nerve and the right optic tract and nerve.

Dr. GOWERS had seen a case of tumour in this situation which was associated with optic neuritis. He had also observed a case where pressure at the back of the orbit had produced an atrophy of the optic nerve resembling that of locomotor ataxy.

Dr. LEDIARD (Carlisle) communicated notes of a case of Epithelioma of Orbit in a man seventy-four years of age, who had previously suffered from epithelioma of the lip. The orbital growth was of four years' duration, had destroyed the lower eyelid and partially involved the eyeball. The diseased structure was removed.

HARVEIAN SOCIETY OF LONDON.

THE annual meeting of this Society was held at the Stafford Rooms, Edgware-road, on Thursday evening, Jan. 6th, 1881, for the election of officers and the President's address.

It is usual, in addition to the ordinary routine business, to hold a conversazione on the occasion of the annual meeting, but the council recommended that this year the soirée should be on a larger scale, and be held at the South Kensington Museum in the summer, in consequence of the Society having reached the age of fifty years. Mr. Henry Power, the president, delivered a most interesting address. He commenced by thanking the members for the honour, unprecedented in the history of the Society, that they had conferred upon him in electing him for the second time to fill the office of President. He referred to the ready assistance he had at all times received from the secretaries, Mr. Field and Dr. Fothergill, and attributed the great increase in the numbers of the Society and the corresponding improvement in the finances to their unflagging activity and zeal. He then gave a short account of the several papers that had been contributed in the course of the past session, including those from Dr. Broadbent, Dr. Ferrier, Mr. Knowsley Thornton, Dr. Meadows, Mr. Teevan, Mr. Field, and many others. Mr. Power then proceeded to point out the circumstances which were gradually effecting improvement in the general status of the profession, and the estimation in which it was held by the community at large. He thought that this was due to several causes—first, to the younger members of the profession being more uniformly drawn than formerly from the middle or better classes; secondly, to the circumstance that the education afforded to them was very superior to that given to the last generation, the time being more prolonged, whilst the subjects were taught in a more practical manner; lastly, the methods adopted in physiological research were evidently being adopted in the practice of medicine, rendering it far more precise and accurate in the present than in the past.

The following is a list of the names of gentlemen elected as officers of the Society for the year 1881:—President: Mr. Henry Power. Vice-Presidents: Mr. F. J. Gant, Dr. W. H. Day, Dr. Milner Fothergill, and Mr. H. Sewill. Treasurer: James E. Pollock. Hon. Secretaries: Mr. George P. Field and Mr. Malcolm Morris. Council: Drs. G. C. P. Murray, W. Squire, G. Danford Thomas, J. W. Langmore, T. T. Whipham, J. F. Payne, F. A. Mahomed, and Messrs. Alfred Cooper, Osman Vincent, Robert Argles, W. Towers Smith, and W. Rayner.

WEST KENT MEDICO-CHIRURGICAL SOCIETY.

AT the third meeting of this Society, held on the 3rd ult., Dr. Hitchcock (President) in the chair, Mr. S. OSBORN, F.R.C.S.E., read a paper on Phimosis as a cause of Hernia in Infants. Having, in his capacity as Surgeon to the Surgical Appliance Society, to examine and apply some hundreds of trusses in the course of the year, the frequency of phimosis in combination with rupture in infants had struck the author repeatedly. The phimosis in all these cases he was certain was the undoubted cause of the rupture, and might be thus explained: After the descent of the testicle into the scrotum has been accomplished the vaginal process of peritoneum, through which it descended, begins to close and become converted into a fibro-cellular cord. But the testicles having but lately descended (the left coming down between the seventh and eighth month of fœtal life and the right between the eighth and ninth month), the uniting medium is but yet young, and not being sufficiently organised is easily broken down by any strain thrown upon it. Phimosis occasions that strain from the impediment which it offers to the outflow of urine. For the mechanism of ordinary micturition is effected by the contraction of the muscular coats of the bladder and urethra, but in cases of obstruction to the outflow of the urine extraordinary force is called into action, and this is effected by the contraction of the abdominal walls pressing upon the bladder, whilst the diaphragm is also at the same time in a state of tension. By this means pressure is exerted over the whole of the abdominal wall, and the apertures by which the testicles have descended to the scrotum being always the weakest points of the abdominal surface, they naturally give way under the strain thrown upon them. In other words, the child, straining to pass his water, forces the abdominal contents downwards upon the weak points at the inguinal canals, and rupture on one or both sides results. It might even be said that the canal which has been the last to close, or, in other words, that side on which the testicle was the last to descend, is the side on which the rupture usually occurs; and, knowing that the right testicle is generally the last to descend, we naturally find that hernia in infants is also met with with greater frequency on this side. That the rupture occurs on the side on which the testicle was the last to descend is only what might be expected, for the uniting medium which is effecting a closure of the canal on this side is not in so advanced a condition of organisation as on the other side, where the testicle has taken its place prior to the other. It is thus easily seen how a single truss frequently produces a double rupture. The cause of the obstruction to the outflow of urine is still present in the phimosis, and one inguinal canal being guarded by the single truss, the abdomen gives way at its next weakest point—viz., the other inguinal canal, and a double rupture is the consequence. Such a result might have been prevented by early circumcision. The hernia in these cases is generally scrotal, or, if not, it soon becomes so by the wedge-like projection of the intestine; and as to whether it be congenital or infantile in variety depends upon the amount of the funicular process of peritoneum which becomes converted into fibro-cellular tissue, or which has been broken down by the aforesaid propulsion of intestine. The operation of circumcision, as performed upon young children, and which was done in all of the cases the author had spoken of, is both easy of performance and effective in its results. No sutures are ever required, children bear the pain well, and the parts are usually well in a week or ten days. The hernia then stands every chance of being effectually cured by the application of a truss, the exciting cause having been removed; at all events a double rupture is prevented by its early adoption. He would suggest that whenever an elongated or contracted prepuce is present in infants, the sooner circumcision is performed the better; thereby the more serious complaint of rupture will be prevented.

Reviews and Notices of Books.

The Quarterly Journal of Microscopical Science. No. LXXXI. Jan. 1881. London: J. & A. Churchill.

THIS part contains the following memoirs:—1. Notes on a Peculiar Form of Polyzoa, closely allied to Bugula, by George Busk. 2. On the Germination and Histology of the Seedling of Welwilischia mirabilis, by F. Orpen Bower. 3. Notes on some Reticularian Rhizopoda of the *Challenger* Expedition, by Henry B. Brady. 4. On the Head Cavities and associated Nerves of Elasmobranchs, by Milnes Marshall. 5. Contributions to the Minute Anatomy of the Nasal Mucous Membrane, by E. Klein. 6. Histological Notes, by E. Klein. 7. On the Intra-cellular Digestion and Endoderm of Quinocodium, by E. Ray Lankester. 8. On the Micrometric Numeration of the Blood-Corpuscles and the Estimation of their Hæmoglobin, by Mrs. Ernest Hart. 9. Preliminary Account of the Development of the Lampreys, by W. B. Scott. 10. On Some Appearances of the Red Blood-Corpuscles of Man and other Vertebrata.

The chief paper of interest to professional readers is that of Dr. Klein on the Minute Anatomy of the Nasal Mucous Membrane, in which he particularly describes the organ of Jacobson. The structure known under this name is found in a rudimentary state in man at the lower part of the nasal septum; but it is highly developed in the guinea-pig, in which animal Dr. Klein has chiefly examined it. It is a tubular structure, flattened from side to side, and leading in front into the ductus Stenonianus, which opens into the oral

cavity. It terminates behind cæcally. It is surrounded not by the bone of the septum, but by hyaline cartilage, which forms a more or less complete capsule for it, separate from the cartilage of the septum and below the septum. The lateral wall of the organ of Jacobson consists of the epithelium lining the cavity, a subepithelial fibrous layer, a layer of cavernous tissue, and a layer of glands. The epithelium resembles that of the nasal mucous membrane, generally consisting of ciliated columnar cells, with some goblet cells. The glands consist of more or less branched and convoluted tubes. The *median* wall is covered with a thick sensory epithelium, and presents many fine nerve fibres, chiefly derived from the olfactory nerve, but in part also from the naso-palatine nerve. Dr. Klein describes these cells very minutely.

Surgical Lectures delivered in the Theatre of the Westminster Hospital. By RICHARD DAVY, M.B., F.R.C.S., Surgeon to the Hospital. London: Smith, Elder, & Co. 1880.

MANY of the lectures collected in this volume have been already published in full or in abstract in one or other of the medical journals. They each and all bear the impress of originality, especially perhaps in the manner in which the subjects are treated, which is slight, dogmatic, and frequently humorous and quaint, though some may think it hardly advisable to have crystallised in this manner all the pleasantries of the lecture-room. The lectures to which most interest attaches are those on the treatment of talipes by excision of the tarsal arch, and on the compression of the common iliac vessels by a lever passed per rectum. The latter method is an established practice now in amputation of the hip-joint, and is certainly a valuable surgical acquisition, for which we are solely indebted to Mr. Davy. His method of applying Sayre's plaster-of-Paris jackets to patients suspended in hammocks has many advantages over the extension plan of Dr. Sayre, and is hardly so widely known as it deserves. Mr. Davy gives a table of twenty cases of excision of the knee-joint, all of them followed by recovery, but only two of these patients were adults, the other eighteen ranging from two to fifteen years of age. This operation is not generally performed so frequently at such an early age, and it would be exceedingly interesting to know the ultimate result of the operation in these cases, whether the limbs are so shortened as to be but of little service. In two of the cases of complete excision, only fibrous anchylosis was obtained, and in one of the cases amputation of the limb was afterwards performed. Mr. Davy makes a contribution to the discussion of the best means of treating wounds, which he considers to be to leave them without any dressing at all.

Lectures on the Surgical Disorders of the Urinary Organs. Delivered at the Liverpool Royal Infirmary. By REGINALD HARRISON, F.R.C.S., Surgeon to the Infirmary, &c. Second Edition, considerably enlarged. London: J. & A. Churchill. 1880.

THIS edition is double the size of the former one, twelve new lectures being added, and the old lectures variously improved. The subject of Stone in the Bladder in particular is more fully dealt with both from its theoretical and practical points of view. Mr. Harrison supports Drs. Carter and Ord in their view of the influence of colloids in the formation of calculi, and he advances the suggestion that irritation of the urinary organs, causing an increased secretion of colloidal mucus, leads to concretion of the solid constituents of the urine. While we may admit that there is some evidence in favour of this view, we cannot lose sight of the important influence of the composition of the urine in the deposit of calculous material.

The present edition is considerably increased in value by the new matter added; and even if we cannot agree with all the views expressed, it is impossible to read these Lectures without profit and interest.

Transactions of the Pathological Society of London. Vol. XXXI. London. 1880.

As we furnish so full a report of the meetings of the Pathological Society, it is hardly necessary to do more than mention the publication of the annual volume of the Transactions. Like its predecessors, it is full of careful descriptions of interesting pathological conditions, and, although it does not contain any "discussion," or "report" similar to that of the Pyæmia Committee last year, it is worthy to rank with any of its predecessors. There are a large number of well-executed engravings, and a few coloured plates, the Council having spared no pains or expense in the preparation of the volume. The descriptions of the specimens exhibited "by card" are printed in small type.

ABSCESS OF THE BRAIN IN A FŒTUS.

To the Editor of THE LANCET.

SIR,—The following case seems to me a rare one. I was called in to attend a multipara, who had engaged a midwife. The latter, finding something wrong, sent for me. The patient had been suffering much pain for several days, but true labour pains had only been present for five or six hours. She had not felt the child for ten days, and was convinced that it was dead. On digital examination a finger-like pouch was found projecting into the vagina. The finger being carefully passed up to the neck of the womb, it was found to be dilated to the diameter of about two inches. The finger encountered a detached bone, evidently one of the parietal bones, and could be passed on both sides of the bone. During the progress of the labour the pouch became larger, and when the membranes broke it was found to consist of the loose scalp filled with some fluid. When the child was born it had apparently been dead for the period supposed by the mother. The skull was collapsed, and contained about a third of its usual contents; the bones were all loose, and several completely detached from their articulations, and entirely denuded of pericranium and dura mater. I had no knife with me at the time, and was only able to make a very incomplete examination next day, but I made then an incision through the scalp, when a quantity of pus discoloured with dark blood gushed out; pus of the same kind was found to have filled the mouth and nostrils; but little brain tissue could be detected, and that appeared to consist entirely of the convolutions; the whole of the base of the brain was broken up. On passing a finger into the skull the bones of the base were felt bare and loose, and with one finger in the mouth and another in the skull the palate and sphenoid bones could be lifted up and moved about quite freely. The rough edges of the sphenoid could be felt distinctly.

The patient attributed the death of the child to two frights she had received during pregnancy; the first when she had just quickened, and the second six weeks before the birth. Could the first have caused hydrocephalus, and the second have set up acute inflammation, ending in suppuration? I forgot to state that the placenta was small, and had numerous hard fibroid masses in it. There was an offensive discharge from the uterus for a few days after the labour, and carbolised injections were freely used; but there were no bad symptoms, and the temperature never rose above 101° F. Perfect and rapid recovery took place. There was no trouble with the breasts.

I am, Sir, yours, &c.,

R. H. BAKEWELL, M.D., &c.

Hokitika, New Zealand, Nov. 1st, 1880.

THE BRITISH MEDICAL BENEVOLENT FUND.—At the annual meeting of the above Fund, held on the 18th inst., the following resolution was carried:—"That the best thanks of this meeting be given to the Editor of THE LANCET for the kind services rendered by him to the Fund."

THE LANCET.

LONDON: SATURDAY, JANUARY 22, 1881.

WE have recently on two or three occasions foreshadowed a new and hopeful departure in the movement for Medical Reform, the principal aims or provisions of which we may now more particularly indicate. It is reasonable that, with a new Parliament, this question should be put into its best form, and presented under conditions calculated to make the strongest impression on the Government and the Legislature. This is what we mean by a new departure. Let us briefly sketch the more prominent features of this fresh demand for medical reform.

In the first place, it is to have for a basis the general judgment of the profession. It is not to be the work of one association or of another, but of the profession itself. Associations, however large, are not the profession. There is a feeling that they can be manipulated by cliques and committees and wire-pullers. We share that feeling, and we participate in this movement only on the understanding that the profession is to take the leading part, and that the demands made are to be based on the judgment of the profession, so far as that can be ascertained. To accentuate this essential feature of the new effort an appeal to the profession will be made, in the name of a Conference in which various associations were represented, but in which none were predominant, and the chairman of which (Dr. ANDREW CLARK) has shown himself to be most deeply and disinterestedly in sympathy with the profession. It is refreshing to find a physician of the highest standing who believes the profession to be greater than its corporations, and who does not think so meanly of it as to be afraid of giving its experienced and hard-working practitioners representation in the Medical Council. So much for the basis and the new executive of this movement.

We now come to the essential features of the reform embodied in the Bill of the Conference, which it must be clearly understood is to be a measure framed by the Conference, and not by any one of the bodies represented in the Conference. The chief provisions may be briefly stated thus:—

1. It is to provide for the establishment of a Conjoint Board in each division of the kingdom.

2. It is to reduce the number of corporations in the General Medical Council by three.

3. It will give direct representation to general practitioners in each division of the kingdom.

4. It will make the General Medical Council a responsible body, with authority over curricula, examinations, &c.

5. It will require equality in curricula, examinations, and fees for examination in each division of the kingdom.

6. It will recognise the claim of universities to have their graduates or candidates for their degrees exempted from all but the clinical or practical part of the examinations of the Conjoint Board.

7. It will strengthen and amend the clauses which punish fraud on the public by false pretences to being qualified to practise medicine.

Any Bill that fails to ensure these points of reform must be an imperfect measure, and our interest in it will abate or cease with any serious unfaithfulness to these principles. The establishment of Conjoint Boards is, of course, simply an indispensable step. The "nineteen competing bodies" must cease to compete, and, barring the three which it is proposed to relieve from further public duties, must co-operate in the formation of a Conjoint Board in their respective divisions of the kingdom.

Everybody feels that there are too many Corporations, and that their influence in the Council is hindering and injurious. The difficulty has been to know how best to diminish it. Mr. SIMON'S proposal is to consolidate the representation of the corporations. "If," he said in his evidence before the Select Committee, "the authorities were consolidated for licensing and examining purposes, I do not see why they should not be consolidated for Council purposes, and why the Council should not be reduced to one-half its size." This is almost precisely the proposal of THE LANCET Bill in 1870, which gave a Council of twelve, four elected by the Crown, four by registered practitioners, and four by the consolidated and co-operating authorities—two for England, and one respectively for Scotland and Ireland. And there is still much to be said for this kind of Council. Meantime we must be content with relieving a corporation in each division of the kingdom of its public duties—namely, the Apothecaries' Society in England and in Ireland, and the Faculty of Physicians and Surgeons in Glasgow. If any worthy licentiate of these bodies thinks he is going to lose anything by this reform, let him be undeceived. He has no more part or lot in the representation of these bodies than he has in the thriving drug trade carried on by the two former societies. The representative of the Council of the London Society in the General Medical Council is appointed by 24 persons, called mysteriously the master, the wardens, and the assistants. The representative of the Apothecaries' Hall of Ireland is elected by 31 persons, called the General Court or Council. The representative of the Faculty of Glasgow is elected by 170 persons, known as Fellows of the Faculty, differing from their humbler associates, the licentiates, not in having passed any higher examinations, but in having paid two additional sets of fees—the main care of Corporations. It is high time that room was made for the direct representatives of general practitioners by the abolition of the representation of 24, 31, and 170 persons respectively. The modest disfranchisement of the Conference Bill leaves two Royal Colleges in each division of the kingdom, while it gives a vote to every registered practitioner for representatives that will view questions in the broad light of the profession, instead of the narrow light of small and almost commercial corporations. Another serious reason for relieving these superfluous corporations of the duties of medical authorities is to keep down the conjoint fees. These bodies are not needed. As Sir JAMES PAGET said, no one with the diploma of two Royal Colleges will care to ask for the diploma of the Faculty of Physicians and Surgeons. Still less will he care to have the licence of

either of the Apothecaries' Companies. In the name of all that is reasonable, then, let us not entail on future generations of medical men a tax for their superfluous and injurious maintenance.

We must defer the further notice of the Conference Bill. Meantime we urge on every practitioner to give prompt and immediate consideration to its proposals.

THE highest form of statesmanship does not wait until questions of public interest have so "matured" as to be mischievous, before it begins to legislate. Government, by or in consequence of agitation, has many drawbacks, not the least of which are the disturbance and final withdrawal of confidence which have to be produced before a Ministry will move. This is a consideration which may be worthy the attention of our rulers in regard to not a few of the questions of reform which have been persistently pressed upon their notice session after session during a long series of years! It is not the fault or weakness of one party in the State more than of another to plead that questions are not "matured" until agitation has done its utmost to compel legislation, and at the same time wrought mischief by disturbing and destroying public confidence in the system it is deemed necessary to reform; but it is a very serious fault, and one from which the community at large severely suffers. The particular manifestation of this evil to which we are at the moment desirous of directing attention is the provoking delay of Lunacy Law Reform, until not only is agitation drifting into bad courses, but, as a fruit of the shaking of confidence it has produced, the public is resorting to a policy of concealment at once disastrous in itself and fraught with new and personal dangers. Let us at once say that we have nothing to urge against the *treatment* of lunacy or mental disorder in private houses; the evil to which we point is concealment—a concealment forced on the friends of the insane by the fears excited by agitation, and which the Legislature will not allay.

The proportion per cent. of lunatics in private asylums and of persons known to the Commissioners as insane is decreasing. What does this mean? With that short-sightedness common to public officials, the Commissioners in Lunacy and their friends and supporters interpret the figures as indicative of a decrease, or, at least, a diminished rate of increase, in the number of occurring cases of insanity. They are oblivious to the fact that the long vexing of this question of reform, and the opposition offered to a satisfactory settlement of the issue raised in the mind of the public, have had the effect of destroying confidence in the asylum-system and the protective power of the Commission; and that, in consequence of this altered feeling, the friends of the insane do not—unless driven to take the justly dreaded step—bring their patients under the official cognisance of the Commissioners. Never before, perhaps, was the practice so general as at this moment of keeping persons of unsound mind in the houses of members of their own families under the care of "trained nurses" and attendants. The Commissioners know absolutely nothing of these cases. The law, as it stands, gives them no jurisdiction in the matter. It is only when some person makes profit by taking charge of a lunatic the poor sufferer from mental disease comes under the *protection*—such as it is—which the Commissioners are able to afford. In this case, as in many others, there is practically one law for the rich and another for the poor, but in the present instance the rich fare the worst. Patients among the fairly well-to-do classes are kept at home in carefully padded rooms under mechanical—or irritable muscular—restraints, or are farmed out under the care of persons who have no special fitness for, or the experience which sometimes does duty for fitness, in the management of the insane. In this latter case, as some one *does* "make a profit" by them, the lunatics ought to be known to the Commissioners, but as a matter of fact they are not. Patients of this class are described as "nervous," "weak-minded"—anything except "insane or of unsound mind,"—and practitioners in mental disease can scarcely be blamed for lending their sanction to the secrecy.

All this, and it cannot be disguised that it constitutes a most perilous state of affairs, is the direct and inevitable fruit of agitation without legislation. The public have lost confidence in the management of private asylums, and while the Government is too busy to attend to the real needs and grievances of the community, the friends of the insane resort to the only expedient open to them—namely, keeping them under their own personal observation. It is not improbable that the larger part, if not the whole, of the seeming decrease of the total of "private patients" upon which the Commissioners in Lunacy are disposed to congratulate themselves and the public, may be accounted for by the measure to which the growing distrust of the public is driving the relatives of the mentally diseased. This is a gigantic evil, and we must hold successive Governments responsible for the consequences which are beginning to ensue. There is something so ludicrous in the state of the law which allows private patients treated in their own families to remain unregistered, while it makes the process of registration by "certificates" a terror to every sound mind, that if it were not a very grave matter the predicament in which the Commissioners are involved might be regarded as making them and their official work a laughing-stock. It is, however, impossible to look at the matter in this irreverent light. The gravest consequences are certain to be entailed on the community if legislation is not hastened, even at the cost of distracting the minds of our representatives in Parliament for a moment, from the more "interesting" questions of Irish "Boycotting" and land-law reform.

We are not alarmists, and we have certainly no wish to hamper the hands of the Ministry at this conjuncture, but it is a public duty to speak out; and—in the presence of certain serio-comic efforts of the Commissioners in Lunacy to search out and prosecute a few isolated cases of secret "farming," and, in consequence of facts known to ourselves—to show that the practice of evading the miserable law which exists is becoming widespread, and the perfunctory and sensational discharge of duty by the legal guardians and protectors of the insane is degenerating into a farce—a more conspicuous farce than the proceeding of registering a long catalogue of names, and professedly watching over the persons who bear these names, without having the means or power of even identifying them! The time has come to deal plainly with the subject of Lunacy Law Reform, and if there is, as would seem to be the fact, a settled determi-

nation in official circles to play with the question, then we must press it upon their consideration more forcibly, and with greater earnestness than we have hitherto deemed necessary. It cannot be endured that official apathy, and the misconstruction placed on official figures by incompetent statisticians, should bring down on the community evils which it will hereafter cost a world of trouble and expenditure to cure. If once the practice of *concealing* lunatics in private families is allowed to become general, as we affirm it *is* becoming general, it will be impossible to eradicate the evil by any tardy change in the law. Our own strong leaning is, as we have said, towards a policy of placing mental disease on the footing of ordinary disease, and leaving it to be treated by the medical profession on general principles, and, in the case of private patients, in private houses, without — except in cases of special necessity — their being taken out of the protection of their own families. We think the best results would be gained by this method of dealing with the question, the legal process of imposing social disabilities upon lunatics being left to the lawyers, as a matter totally apart, and entirely distinct and different in its nature. Meanwhile, all are agreed that the *hiding* of lunatics in upper and back rooms where they are subjected to nameless cruelties under the guise of kindnesses is a wrong of the greatest magnitude; and it is this hiding and this secrecy which the reckless or perverse delay of reform encourages, and which the Commissioners in Lunacy mistake for a "decrease" of lunacy in the class of private patients. It is time that public opinion should be moved to protest.

M. RICHET, in a lecture delivered as one of a course auxiliary to that of the Faculty of Medicine of Paris, has just given a very full and complete *résumé* of the present state of our knowledge of Rigor Mortis, which has engaged the attention of observers from the time of LOUIS, who in 1752 wrote an essay upon it, in which he pointed out that it was one of the principal signs of death. NYSTEN, in the early part of the present century, demonstrated that cadaveric rigidity is due to the condition of the muscles, since if the ligaments of the joints, the fasciæ, and the aponeuroses, are all divided, rigor mortis persists, whilst it is removed or prevented by division of the muscles or by the separation of them from their attachments. BROWN-SÉQUARD and KÜHNE next examined the phenomena in question minutely, the former showing that it could be removed by the injection of blood into the vessels, and the latter demonstrating that it was essentially a chemical action. It may be stated generally that rigor mortis is never absent; the few cases in which reliable authorities have believed that it has not occurred having probably been instances where it has occurred extraordinarily early or late. It occurs in all animals, both vertebrated and invertebrated. In fishes it takes place almost instantly after death, whilst in frogs, if due precautions be taken, it does not occur until after the lapse of eight or ten days. It has no relation, therefore, to the temperature of the blood of the animal. The first muscles to undergo rigor mortis appear to be those raising the lower jaw, as the masseter, temporal, and pterygoid, which are very irritable muscles. M. NIDERKORN finds that in 113 subjects rigor mortis was complete at the fourth hour in 31, at the sixth hour in 20, at the fifth in 14, at the third in 14, at the seventh in 11, at the eighth in 7, at the tenth in 7, at the ninth in 4, at the thirteenth in 2, at the second in 2, and at the eleventh in 1. It commences about two hours after death, and in the human subject is usually complete about the fourth hour. It may supervene whilst the animal is still warm, as is seen in those which have been hunted to death. On the other hand, its appearance is retarded by cold, whilst its duration is almost indefinitely retarded by it. A muscle which has become rigid after death becomes still more rigid if exposed to a temperature of 120° F. This increase, according to KÜHNE, is due to the coagulation of the serine and caseine contained in the muscular juice. Mere congelation of a muscle does not cause it to lose its irritability, but it very rapidly becomes rigid when thawed.

The remarkable positions sometimes assumed by men killed on the field of battle have been described by many observers, and demonstrate that rigidity may supervene at the moment of death. BROWN-SÉQUARD has, indeed, recorded a case of adynamic typhoid fever, in which the jaws and limbs became fixed, whilst the heart still continued to beat; and quite lately the same thing has been recorded by M. BOCHEFONTAINE in dogs poisoned with salicylate of soda, and M. RICHET has observed it in animals poisoned with medium doses of strychnia. In these cases all the muscles were rigid and unexcitable, with the exception of the heart; and artificial respiration could only be maintained with difficulty owing to the rigidity of the chest. Division of the nerves supplying a muscle appears to have little or no effect in accelerating the occurrence of rigor mortis, and, according to HERMANN, neither exposure to oxygen nor to the vacuum of an air-pump exerts any influence.

In becoming rigid, muscles slightly diminish in volume; they shorten less, at least with moderately heavy weights, than muscles in contraction; they entirely lose their irritability, and their elasticity is greatly impaired. Heat is eliminated whilst rigor is being established.

In regard to the cause of rigor mortis, which is an extremely interesting point, M. RICHET is of opinion that, as KÜHNE originally maintained, it is a chemical process; but this process is a phenomenon not of life but of death. The myosine of the muscle coagulates. The acids, which are constantly being formed and as continuously removed during life, accumulate after death in the muscle, and gradually effect the solution of the myosine, and then the azotised matters undergo decomposition and develop ammonia, which, in its turn, dissolves the myosine, and thus occasions the disappearance of the rigor. Speaking generally, rigor mortis is a chemical phenomenon, characterised by the coagulation of the myosine, and may be considered as the commencement of the death of the elements of the muscle.

THE recent correspondence in *The Times* on the restraint of scarlet fever furnishes another and most striking illustration of the injudiciousness, and even mischievousness, of medical men discussing in the general press questions of a strictly technical nature. In this case it may be said that the subject under consideration is of great interest to the public at large, even greater than to the profession. In

other words, that it is both a public and a professional subject, and that it is indifferent whether it be made matter for general or for professional discussion. But so far as the general public is concerned, this presupposes that the strictly technical questions from which the public considerations have to start have been fairly settled by those who are presumed to possess special opportunities of, and the particular training for, judging them, and that there is some reasonable accord among these skilled individuals as to the judgment formed. Let us see how this stands in the correspondence referred to, and ask in what light it must present the medical profession in perhaps the most familiar disease it has to deal with in this country.

First, Dr. WYNTER BLYTH writes to *The Times* stating that it is "possible, by a very simple process, to render scarlatina convalescents absolutely harmless." In support of this he sets forth a theory of the duration of the infectiveness of scarlet fever peculiar to himself, and, as yet, unconfirmed and untested by other medical observers, and then proceeds to show that, notwithstanding the prettiness of the theory, scarlet fever may continue to be infective as long as other medical observers have found it to be. Further, he proceeds to illustrate his position by so-called "experimental" proof; and then he proceeds to qualify his recommendation by adding that, "providing the process in its minutest details is carried out thoroughly, a patient may mix with impunity with healthy people as early as the eighth day, if free from fever"; and, again, "it is only in those cases in which the process recommended has been followed out thoroughly, under skilled supervision, that I would dare to recommend the exposure of a convalescent at so early a period. In any other case such a procedure would be fraught with great public danger." Setting aside the technical questions which are here raised, it must be obvious that this qualification neutralises the public-health aspect of the case, and reduces the application of Dr. BLYTH'S proposed extension of the late Dr. WM. BUDD'S plan of "laying" the contagious dust scattered from the skin of a person sick with or convalescent from scarlet fever, by anointing with oil or glycerine or other unctuous material, pretty much to the practice of it now in vogue. Dr. BLYTH'S proposition of establishing "disinfecting halls" for convalescents from scarlet fever does not much mend the matter as a practicable public-health suggestion.

A proposition of this sort addressed to the general public seemed to us at the time of its being made to be so obviously contradictory in the terms in which it was made that the technical elements scarcely called for remark, and the public might have been credited with sufficient judgment to determine for themselves how it would affect them. But this was not to be. Dr. ALFRED CARPENTER comes to the front to say that "he had never had reason to doubt the efficacy" of the process advocated by Dr. BLYTH. Next Dr. BROADBENT points out, from his exceptional experience, that the "process" is practically unattainable, except in hospitals and the houses of the wealthier classes, and even there is apt to fail in making the convalescents harmless. Then Dr. MAHOMED follows in the same vein as Dr. BROADBENT, and insists, also from exceptional experience of scarlet fever, upon the prime necessity of "isolation" of cases. Lastly, Dr. W. SQUIRE steps into the fray, refusing to be content with anything short of a quarantine (and a *real* one, to boot) of forty days for convalescents from scarlet fever.

What but bewilderment to the public can arise from a discussion of this sort? They can form no correct judgment of the respective values of the several statements of the writers, and what must be the general result but to engender a doubt both in households and among sanitary authorities of the value of "isolation" as a precaution against the extension of scarlet fever. To the householder it suggests an escape from an extremely irksome measure, and to the sanitary authority an escape from expenditure upon infectious disease hospitals. In the latter case it is difficult to exaggerate the mischievousness which might thus arise from the hasty publication of a suggestion which, at least, should have been supported by evidence having some proportion to the magnitude of the issues it involved. At present the suggestion, as a public health one, is directly opposed to existing experience. If subsequently it should be shown that there are stronger grounds for its acceptance than are now apparent, no one would welcome it more than ourselves. But there are pathological and clinical considerations to be dealt with which must be discussed in other places than the public press before we can reasonably indulge in such a prospect. The question as to the "laying" of scarlatinal dust as a mode of preventing the extension of scarlet fever still remains as it was stated in the well-known memorandum of the Local Government Board, issued first under the signature of Mr. JOHN SIMON—viz., "It is believed that the dispersion of contagious dust from the patient's skin is impeded by keeping his entire body (including limbs and head and face) constantly anointed with oil or other grease; and some practitioners also believe this treatment to be of advantage to the patient himself. When the patient's convalescence is complete, the final disinfection of his surface should be effected by warm baths (with abundant soap), taken on three or four successive days, till no trace of roughness of the skin remains. Not until this has been done, nor without the greatest care that the clothes are clean and free from infection, should the patient, however slight may have been the attack, be allowed to associate with persons susceptible of scarlatina."

IT would be hard to say whether the Council of the Royal College of Surgeons or the profession is to be the more congratulated on the announcement we were able to publish last week—namely, that the Council has resolved to discontinue, from and after the 31st of December next, the preliminary examination at present conducted under its authority by the College of Preceptors, and also to improve the professional examinations for the diplomas of Member and Fellow by extending the examination in medicine and making midwifery a compulsory subject of examination on and after the 1st of next January. The importance and significance of these resolutions can only be properly appreciated by those who have studied the behaviour of the various Corporations throughout the United Kingdom towards all questions of medical education and reform. The Council of the Royal College of Surgeons, though long un-

yielding and at times resentful, has, more perhaps than any other similar institution during the past ten years, manifested a susceptibility if not a readiness to be influenced by outside opinion. The formation of the Board of Examiners in Anatomy and Physiology, separate from the Court of Examiners in Surgery, was an enormous concession to the spirit of modern times, and in its turn smoothed the way for the further adaptation of dividing the Board into examiners in anatomy and examiners in physiology. This was well as far as it went; but, in spite of what the Council had done, there were still two serious grounds of complaint. The preliminary examination was notoriously inadequate, and the chief professional examination was seriously incomplete in so far as the diploma acquired through it was held to be sufficient to place anyone upon the Medical Register as a legally qualified practitioner. A person furnished with the diploma of Member of the College might legally engage in general practice, though he had been submitted to the most meagre examination in medicine, and had not been examined at all in midwifery. Had it not been for the long-cherished hope of a Conjoint Scheme it is difficult to imagine that such a scandal would have been allowed to continue. All this is now to be changed. The responsibility of the preliminary education of the medical students will henceforth devolve entirely upon the General Medical Council. It, therefore, becomes imperative upon this body not only to see that the wish expressed by the Council of the Royal College of Surgeons is carried out—namely, that the preliminary examinations should be held at the most convenient times and places,—but also to take special pains that the examinations accepted in lieu of those held by the College shall be thorough and comprehensive. The profession and the public alike will have cause of complaint if the largest and most important corporation should in the interests of education give up its preliminary examinations while minor ones are allowed to continue theirs. It is quite as important to guard the side entrances as the main portals. There can be no uniformity in the requirements of preliminary education until these examinations are conducted under the authority and supervision of one central body, like the General Medical Council. The general educational and examining bodies should be entrusted with the management of the examinations, and the General Medical Council should define the regulations and requirements relating thereto. In this way the General Council may control preliminary education, and indirectly prescribe and determine its character.

THE occasion of the distribution of prizes at the Ceylon Medical School, on Nov. 29th last, was rendered additionally interesting by its being made the celebration of the completion of the Koch Memorial Clock Tower, which now stands prominently forward in front of the De Saysa Museum and Hospital. Shortly after the lamented death in 1877, from accident, of Dr. Koch, Principal of the Medical School and Surgeon to the General Hospital, the members of the Civil Medical Department determined to raise a subscription among themselves to found prizes for operative surgery in memory of their deceased friend. Funds for these prizes having, however, been forthcoming from another source, the sum collected was increased by contributions from the general public, with the result of obtaining sufficient for the erection of the Clock Tower above named.

Annotations.

"Ne quid nimis."

DUNDEE COLLEGE AND ST. ANDREWS UNIVERSITY.

MUCH support is given on all hands to the proposal to which we adverted two weeks ago, that Dundee College and St. Andrews University should be amalgamated; and it is not simple affiliation which is aimed at, but actual migration of the University, in the literal sense of the word, to Dundee. It is urged that St. Andrews is unable to keep up its state respectably, and this is not untrue. The salaries of its professors in 1876–77 ranged from £160 to £585, and since that time, owing to sundry unfavourable circumstances, these emoluments have greatly fallen off. The liberal endowment of the College would renew the youth of our venerable University—a benefit which the latter would repay by the prestige which it would certainly impart to the younger institution. St. Andrews men are specially indignant at another scheme which has been hinted at—that the new college should be affiliated to Edinburgh University; this would mean total extinction for "little St. Andrews" at no very distant date. It is pointed out by some in support of the scheme for simple affiliation with St. Andrews, that such a project would only restore that University to its former dignity; as from 1537 to 1747 the University of St. Andrews contained three colleges, while at present it possesses but two. Unlike the other Scotch Universities, St. Andrews Colleges form distinct corporations from the University, have their own principals, and administer their own property—an arrangement which would favour the connexion of the proposed College with the University. After all the hard wooing that has been going on it would be singular if Dundee men preferred single blessedness, and a house and name of their own.

RESPONSIBILITY AND DISCRETION OF CORONERS.

PENDING the completion of the case, and the decision in the matter of the important application to the Lord Chancellor to dismiss the coroner for West Surrey, it is eminently undesirable to discuss the personal aspects of the case. One of the points raised by the inquiry is, however, of general importance in connexion with the present unsatisfactory state of legislation affecting coroners and their duties. The regulations which guide or control the responsibility and discretion of coroners in their decision as to the necessity for holding inquests, if any exist, are so loose and unsatisfactory as seriously to diminish the value of the coroner's office as a social protection from various forms of crime and criminal neglect. The very remarkable variations in the proportions of inquests held in different towns and counties, so often alluded to by the Registrar-General in his periodical returns, sufficiently point the different interpretation which different coroners put on the present state of the law with regard to holding inquests, even in case of deaths resulting from violence. This uncertainty in the practice of coroners creates innumerable apparent hardships for the public, apart from the manifest dangers arising from the possible neglect to hold necessary inquests. It is evident from the discussion which took place on this point, on the first day's hearing of the application above referred to, that in the opinion of the Lord Chancellor a coroner should have the weightiest of reasons for refusing to hold an inquest in the case of a death from violence which is brought under his notice. The well-known case of Sir Charles Lyell somewhat added to the difficulty and uncertainty in the exercise

of the discretion of coroners in those cases of death from violence in which a certificate of a registered medical practitioner is forthcoming. While, however, a legal certificate of the cause of such a death may afford ground for the decision that an inquest is unnecessary, it would be impossible to accept such a certificate as a necessary bar to the holding of an inquest. The responsibility of refusing to hold an inquest in the case of a death relating to which no medical certificate is forthcoming is, however, so grave, that we doubt whether it should rest with coroners. An examination of the death register for some parts of England and Wales, especially in some of the home counties—Kent, for example—should carry conviction that the time has come for some more definite legislation limiting the discretion of coroners as to the necessity for holding inquests. It may be hoped that the present inquiry may help in this direction.

THE CONTAGIOUSNESS OF GLANDERS.

GLANDERS is now so prevalent throughout the country, and exists to such an alarming extent in London, that any additional evidence we can obtain as to the manner in which it is propagated must be of value. It is not, perhaps, going beyond the mark to assert that not one-half of the cases of this horrible and fatal disorder are reported to the Government; nor is it the less true that proper sanitary measures are very seldom adopted for its suppression. And it is greatly to be feared that the malady is mistaken for other diseased conditions, especially pyæmia, and that sick animals are allowed to live for weeks or months among others, to the great danger of not only these, but their human attendants. It has long been known that glanders is an inoculable disease, and that it could also be produced by transfusing blood from a diseased to a healthy horse or ass, as well as by introducing the virus contained in the nasal discharge into the stomach. It is possible that all the secretions and excretions are more or less infective, the peculiar muco-purulent fluid thrown off by the Schneiderian membrane probably being most active. This discharge has been blamed as rendering the public watering-troughs a source of danger, the fluid passing into the water when glandered horses are allowed to quench their thirst at these valuable conveniences. It has been objected to this notion, that the discharge being heavier than water, falls to the bottom of the trough, and not being readily diffusible, is not likely to be swallowed by other horses watered there. This argument had a certain amount of plausibility, and the friends of the public water-trough movement availed themselves of it when the troughs were accused of being largely instrumental in disseminating the disease.

From a note presented to the Académie des Sciences by Professor Galtier, of the Lyons Veterinary School, it appears that he has been successful in transmitting the disease to an ass, by the hypodermic injection of saliva from a glandered horse. We know that the virulent germs find admission not only through a wound or abrasion, or a thin mucous membrane, such as the conjunctiva, but also by the digestive organs. Saliva readily mixes with water, and those who have watched horses drinking will have remarked that some of the water taken into the mouth escapes by the commissures of the lips and falls back into the trough or bucket; and when drinking has been completed, a certain quantity which has not been swallowed is also returned; so that a glandered horse may largely contaminate the water in a trough with his saliva. Not only this, but when horses drink greedily, it often happens that a portion of the water is returned through the nostrils; so that the nasal, as well as the salivary secretion, may find its way into the mass of water which healthy horses subsequently swallow.

Galtier's experiments also go to show that the glander virus loses its activity when the matters which contain it, whether liquids or tissues, have been completely desiccated for fifteen days. Thorough ventilation of buildings which have been tenanted by glandered horses is, therefore, a very effective means of purifying them.

The diagnosis of glanders is sometimes very difficult, if not impossible, without having recourse to test inoculation; and the animal usually inoculated is the ass, that creature being not only less costly for this purpose, but also more easily infected than the equine species. It is still costly, however, and being large and somewhat expensive to keep during the experiment, other more convenient animals have been proposed for substitution. The rabbit is one of these, but, as M. Colin has shown in the experiments which we described a fortnight ago, it cannot be relied upon as a test animal.

THE CLINICAL SOCIETY.

The meeting of the Clinical Society on the 14th instant was very numerously attended. The ballot for the election of officers and Council for the ensuing year took place, and the following gentlemen were duly chosen:—President: Joseph Lister, D.C.L., LL.D., F.R.S. Vice-Presidents: Drs. William Henry Broadbent, Thomas Buzzard, and Andrew Clark, and Messrs. Brudenell Carter, George Lawson, and Thomas Smith. Treasurer: Mr. Christopher Heath. Council: Drs. Julius Althaus, Thomas Barlow, John Cavafy, James Frederick Goodhart, William Richard Gowers, William Smith Greenfield, George Vivian Poore, Edmund Symes Thompson, Alfred Wiltshire, I. Burney Yeo, Leonard William Sedgwick, and Edwin T. Watkins, and Messrs. Marcus Beck, William Bartlett Dalby, Henry Greenway Howse, Charles Macnamara, F. Howard Marsh, Edward Nettleship, William F. Teevan, and William Spencer Watson. Honorary Secretaries: Dr. Frederick Taylor and Mr. J. Warrington Haward.

The report of the Council was read by the hon. sec., Mr. Howard Marsh, and its reception moved by Dr. Douglas Powell, seconded by Mr. Barker. The President announced that the Council had passed some regulations regarding the preparation and reading of papers, which would shortly be in the hands of the members. Dr. Andrew Clark then proposed a vote of thanks to the retiring President, Dr. E. Headlam Greenhow, F.R.S., for his invaluable services during his term of office. Dr. Clark's motion, which was prefaced by some highly eulogistic remarks, was seconded by Mr. Morrant Baker, and carried by acclamation. Dr. Greenhow, in acknowledging the vote, said that the success of the meetings of the Society was largely owing to the admirable manner in which the hon. secretaries, Dr. Taylor and Mr. Marsh, had performed their duties. He added that he had endeavoured to encourage reports by committees, two of which had still to be presented, one of which—viz., that on the Treatment of Hip Disease—was on the point of completion. On the motion of Dr. Ord, seconded by Mr. Godlee, a vote of thanks was accorded to the retiring Vice-Presidents and other members of the Council, which was acknowledged by Mr. Hulke. Mr. Macnamara then proposed, and Dr. Burney Yeo seconded, a vote of thanks to Mr. Howard Marsh, the retiring secretary, which was cordially carried.

THE KINDERGARTEN SYSTEM.

AMONGST those interested in the education of children, there are probably not two opinions as to the merits of this system, which is gradually becoming known and appreciated in this country. There is, however, a practical difficulty in its application. The education of a child should begin from the moment it takes notice, and for this purpose it is, of course, necessary that those who have charge of the

infant should possess the requisite knowledge. When we reflect upon the position of the nurse in regard to our children, the sway which she exercises over them for many hours in the day and night, we must feel how little is ordinarily known of the competence of those we employ for so responsible a charge. It is not so much the willingness of the nurse to do right that is in question as her knowledge of the principles upon which the early education of a child should be conducted. It is not so long since any old woman, who was too decrepit to do anything else for her living, was considered to possess in perfection the requisites for a sick nurse. The art of cooking was apparently supposed to be inborn in individuals who aspired to the culinary department of domestic service. A tradesman who had failed in his business was as certain to set up a preparatory school as a military man on quitting his profession took to the wine trade. And so, even at the present day, any woman who declares her proficiency is supposed to be endowed with the power of directing the education of a child, the right conduct of which will probably have more influence upon its future happiness than any other circumstance, except the qualities which it possesses by inheritance. It is time that something was done to arrest the present anomalous state of things.

THE MUSCLES IN PHTHISIS.

Two years ago Fränkel, observing how many patients with phthisis presented hoarseness without any corresponding laryngoscopic changes, investigated the condition of the laryngeal muscles in order to ascertain whether any changes in them explained the symptom. In a considerable number of cases, both those in which there were ulcerations in the mucous membrane and those in which the naked-eye appearances were normal, he found constantly an atrophy of the striated muscles. The contractile substance was broken up, the striation indistinct, and a granular opacity had replaced the normal translucence, while in the fibres in which the process was more advanced there was an actual molecular destruction, and ultimate disappearance of the proper tissue. The connective tissue between the primitive bundles also presented a marked cell-formation, and the muscle nuclei were so increased in number as to constitute cellular sheaths to the fibres. This increase seemed to have produced additional damage to the muscular fibres, since these in places were apparently destroyed by the pressure of the groups of cells.

These observations have been confirmed by a series of investigations on forty phthisical subjects by Dr. Posadsky of St. Petersburg, which show that the changes found by Fränkel in the muscles of the larynx exist also in other muscles examined—viz., those of the upper and lower limbs, flexors and extensors, the intercostal muscles, and the diaphragm. The muscular fibres were pale, and exceedingly friable, so that they broke across with undue readiness, and could with difficulty be separated into longitudinal fibrils. This was found in two-thirds of the cases; in the remaining third the muscles were perfectly healthy. The microscope showed a granular degeneration of the fibres in all cases in which the naked-eye changes were observed. In many cases the transverse striation had entirely disappeared. Many of the fibres were strikingly narrowed, and some empty sarcolemma sheaths were seen. Fibres which were not degenerated also showed the tendency to break up into transverse segments which had been noted in the naked-eye examination. Why these changes should be so conspicuous in some cases of phthisis and absent in others it is difficult to say, since the cases with and those without the change presented nearly the same conditions and nearly the same visceral changes. The changes in the interstitial connective tissue described by Fränkel were not found by Posadsky.

FOREIGNERS IN THE MARSEILLES HOSPITALS.

AT the recent sittings of the Marseilles Municipal Council an important discussion arose from the increased expenditure due to the very large proportion of aliens who sought and obtained medical assistance and treatment in the town hospitals. The question suggested itself as to whether it was fair to tax the inhabitants of Marseilles for the maintenance of these numerous strangers. It is estimated that as many as half the patients treated in the Marseilles hospitals are foreigners, and these latter, for the most part, are Italians. On the other hand, it is argued that as the Marseillais cannot, or will not, do the heavier work, and prefer inviting Italian labourers to toil in the docks and at the new buildings which embellish the town, the consequences must be patiently borne. Further, so long as the Italian labourer preserves his health, he aids, by his work and his consumption of taxed provisions, to the wealth and income of the town. There is an Italian benevolent society, as well as an English sailor's home, at Marseilles, and both have rendered great services, but as yet neither nationality has been able to open a hospital for its own people, nor should this be necessary if a true system of reciprocity existed amongst nations. It is precisely the presumed absence of such reciprocity which in any way justifies the complaints of the French against the Italians. It was averred before the municipal council that while it suffices for an Italian to prove that he is ill to obtain admittance to a Marseilles hospital, a French sailor or workman would have considerable difficulty in obtaining similar assistance in an Italian port. This is due, not to any lack of generosity or hospitality on the part of the Italians, but simply that their hospitals are in many instances constituted on a totally different basis. Many of the Italian hospitals are endowed by pious founders, who imposed regulations which, though in no way controlled by the Legislature, must be observed. These charters sometimes exclude strangers from the benefits of the charity, and it can be readily understood that the State has not created national hospitals where there are private hospitals that answer to nearly all the requirements of the locality. These old foundations, many dating back some centuries, no longer meet the exigencies of international intercourse brought about by modern civilisation. They must either be reformed or new wings added free from the trammels imposed by the original donors. But to ensure perfect reciprocity an international treaty should be concluded between the two countries, and its provisions might probably be extended with considerable advantage to other nationalities. That the claims of humanity override all frontier divisions is a principle that the impressionable and poetic people of Italy will readily admit.

THE INTERNATIONAL MEDICAL AND SANITARY EXHIBITION.

WE are glad to be able to state that the guarantee fund for this exhibition shows every sign of being sufficient, and there can be little doubt that the scheme will be proceeded with. Among the chief guarantors are Messrs. Barron, Squire, and Co., and Messrs. Maw, Son, and Thompson, who, as well as Mr. Twining of Twickenham, and Mr. Noble of Henley-on-Thames, have each guaranteed £50. Among the other guarantors are Messrs. Doulton and Co., W. Eassie, Esq., C.E., the Sanitary Assurance Association, the President of the College of Surgeons, Captain Douglas Galton, Mr. Rogers Field, Dr. Steele of Guy's, Dr. Corfield, Mr. G. Godwin, Messrs. Benham and Son, and many others. The amount already guaranteed approaches £700. Many of the guarantors have advanced various sums towards the preliminary expenses, and it is hoped that others will do the same, as these expenses are necessarily not trivial in an undertaking of such magnitude. It is not the intention of the Exhibition

Committee to appeal to members of the profession to assist the guarantee, because it is felt that the expenses of the Congress itself have been, and will be, considerable, and that it would be unfair to make any further appeal to them. Any voluntary assistance, however, will be gladly received, and it is trusted that all who feel disposed to help the committee will do so, for it is evident that the larger the sum guaranteed the less will be the proportionate part to be paid by each guarantor in case the exhibition should not be a success financially.

The exhibition will be divided into a medical section and a sanitary section. The medical section will include whatever is of use in the treatment of the sick and wounded, and in the detection of disease, as well as a class devoted to appliances used in teaching medicine — such as books, diagrams, models, &c. The sanitary section will comprise domestic and hospital architecture; ventilation, lighting, warming; water-closets, &c.; water supply and filtration; health resorts and sanatoria. It will be seen therefore that the scope of the exhibition is wide, and it is highly probable that the 70,000 square feet of area which is the maximum that can be obtained at South Kensington will be found to be none too much. The Exhibition Committee is not yet complete, but at present it is composed of Mr. Erichsen as chairman, Mr. Berkeley Hill as treasurer, Dr. Corfield, Mr. Eassie, Mr. R. Field, Mr. G. Godwin, F.R.S., Mr. W. A. Meredith, M.B., M.R.C.S., Dr. Poore, Mr. E. C. Robins, F.S.A., Mr. Roger Smith, F.R.I.B.A., and Dr. Steele. Mr. Mark H. Judge is the secretary; and we are asked to state that all communications should be addressed to "The Secretary of the Exhibition Committee, Parkes Museum of Hygiene, University College, Gower-street, W.C."

THE CATGUT LIGATURE.

THERE is no part of the surgical practice instituted by Mr. Lister that has excited more interest and attention than his reintroduction of an animal ligature. In spite of many experiments, and much clinical experience, the opinion of the profession is far from unanimous in favour of carbolised catgut. Imperfections in its preparation, and its use in unsuitable cases, may explain a part, if not all, of the failures and accidents that have attended its employment, but its most ardent advocates, we believe, will grant that some improvement in its preparation is still demanded. A recent contribution to our knowledge of the action of catgut ligatures is found in a memoir entitled "Contribution à l'Étude de la Ligature dans le Traitement des Anévrismes," by Dr. G. F. Arnaud. Dr. Arnaud ligatured the carotid or femoral artery of dogs fourteen times, using carbolised catgut, and examined the parts from four to sixteen days afterwards. In nine cases the ligature had entirely disappeared, or was only scarcely appreciable; in two it was partially absorbed, with destruction of the knot; and in three it was little altered. In one of the latter only four days had elapsed from the application of the ligature, which may be held to account for the fact; in the other two, examined on the ninth and sixteenth days respectively, there was an absence of inflammatory reaction and clot, and the ligature was encysted, while for its absorption a rather abundant outpouring of lymph, or development of "granulations," is held to be necessary. In twelve of these cases the outer coat of the artery was found quite unaltered, not having been severed by the ligature; in two it was partially ulcerated, in neither case completely. In twelve cases, the inner and middle coats of the vessel were completely divided, as happens in the use of a silk or hempen thread; in one they were entire, and in one other it was doubtful whether they were partly divided or not. The clot, where not absorbed, was very small, and the obliteration of the artery was complete and firm. Senftleben has stated that internal clot rarely forms with catgut ligatures, but the evidence of these experiments, as well as of others, points to an opposite conclusion. Arnaud concludes that the effect of catgut on the artery is like that of hemp, except—a most important exception—that the outer coat is not ulcerated, the knot of the ligature softening before that occurs. It was noticed, in cases where a strand of catgut was left in the tract of the wound, that there was much more active cell-growth round the ligature than around these strands, with corresponding difference in the rate of absorption. The "absorption" of catgut is thus again fully corroborated, and still more the fact that the use of catgut ligatures is not necessarily followed by the complete severance of the artery, with the attendant risk of secondary hæmorrhage, as always follows the use of hemp or silk.

THE SNOW.

A CONTEMPORARY complains that, while objecting to the measures commonly adopted in dealing with a heavy fall of snow, we do not suggest a specific method of procedure. It is our function, as the organ of medical opinion, to point out dangers to health and life or limb, and it seems decorous to leave the initiation of social reforms to our lay coadjutors. If, however, a suggestion be desired, here is one. On the next occasion of a heavy fall of snow, which seems likely to continue or lie, let the experiment be tried of simply rolling it with a moderately heavy and rough roller, so as to make a firm and roughened road. This will furnish an easy surface for wheels or runners, and the roughed shoes of horses will be, at the same time, able to obtain a hold of the ground sufficient to prevent their slipping. Moreever, when the thaw takes place it will be gradual, and instead of making the whole roadway a quagmire, it will be only commonly wet. As to the foot-paths, let them either be wholly and properly cleared by the able-bodied poor of each parish, or simply strewed with sand or ashes. The present mode of partial scraping produces a surface which is so treacherous as to occasion most of the accidents that occur to the unwary pedestrian.

PEPTONE IN PUS.

PEPTONE was once supposed to be exclusively a product of digestion. Whether it is so or not, its distribution has been found to be very extensive through the body. Its presence in pus has just been demonstrated by Hofmeister. A litre and a half of fresh pus removed from the thorax by paracentesis was taken, the albumen was removed by heat and oxide of lead. The lead was separated by hydrochloric acid and the peptone precipitated from the acid filtrate by phospho-tungstic acid. Thus obtained and separated, it was found to be in all respects identical with ordinary peptone, and when heated to 160° C. it passed into albumen. In composition it appeared to be nearly identical with casein peptone. In order to estimate the amount of peptone, the albumen was removed, and the polarising action of the liquid was ascertained. The peptone was found to vary between ·367 and 1·275 grammes in 100 cubic centimetres, and to be greater, the thicker the pus. In one instance it was found that the amount of peptone in the upper layers of pus was less than in the lower layers. In another case it was ascertained that the serum contained no peptone, while the pus-corpuscles contained abundance. A similar result was obtained with pus diluted with saline solution, and then filtered. The residue contained from two to seven times as much peptone as the filtrate. But if the process of filtration lasts a long time, it may happen that the amount of pus in the filtrate is as great as in the original pus. This is explained by the circumstance that the pus-corpuscles, in their death, give up

their peptone. The same effect is produced by dilute caustic soda. By the destruction of pus cells large quantities of peptone may be liberated, and thus pepton-uria may arise.

STREET-VICTUALLING.

IT would be a seasonable enterprise for any purveyor of food and drink to send into the public thoroughfares, for the convenience of the working classes and the industrial community generally, hand-carts fitted with apparatus for the supply of hot coffee, tea, and food suitable for hasty dinners. If hot food and drinks could be sold in the streets at a small cost in London, as they are in many of the provincial cities and towns, a good trade might be carried on, and a considerable personal service rendered. At present hot chestnuts by day and hot potatoes in the evening are the only eatables to be purchased. Hundreds of hurried or poor foot-passengers would hail such appliances as a means of health, and they would form one of the most direct, and, as we believe, effective, agencies for the avoidance of a common form and cause of drunkenness.

POST-MORTEM EMPHYSEMA FROM GASTRIC ULCER.

AMONG the causes of subcutaneous emphysema ulcer of the stomach is one of the rarest. An instance has, however, lately been reported by Poensgen in the *Deutsches Archiv für Klin. Med.* The patient was a man aged thirty-seven years, who had for three years presented the symptoms of gastric ulcer. He had been treated by washing out the stomach by a douche, and was relieved. A fresh attack of vomiting occurred, and he died suddenly on his way to the hospital. A short time after his death, the abdomen, chest, neck, head, face, arms, and the left leg were gradually invaded by enormous subcutaneous emphysema, which was also found after death in the connective tissue of the mediastinum and beneath the peritoneum. In the smaller curvature the wall of the stomach was perforated by an ulcer, and on the inner surface of the abdominal wall was another ulcer, which had apparently corresponded to the perforation in the stomach, and through it the gas from within that organ had seemingly escaped into the cellular tissue.

SUDDEN ILLNESS AMONGST THE POOR, AND MEDICAL ATTENDANCE.

THERE is a very comfortable doctrine abroad that doctors are at everybody's service in an emergency, and that they are bound to rise from their beds and go to a distant alley to save a life or ease a pain, without the least prospect of recompense. But why is such mercy to be shown only by doctors? Why does not the public share with doctors the cost and the credit of such service? It is society's duty, not that of any single profession, to see that no human creature, however poor, dies without medical aid. A country like this should make provision for the emergencies of its poor, and not throw the whole onus on the much enduring and little paid members of our profession.

WE are informed that the Oxford Examination for the Radcliffe Travelling Fellowship will be holden in Lent Term, commencing on Tuesday, February 8th, at 10 A.M., in the Medical Department of the Museum. Candidates are requested to send their names to the Radcliffe Librarian, Museum, on or before February 1st.

WE are glad to hear that Her Majesty's Office of Works has entrusted Mr. Waterer with the providing and planting of a large number of Rhododendrons and Azaleas in Hyde Park during the approaching season.

PROFESSOR HUXLEY has been appointed to the Inspectorship of Fisheries, vacant by the death of Mr. Frank Buckland. The duties connected with this post are not, we understand, of so engrossing a character as to necessitate his withdrawal from the more important of his other scientific engagements.

THE following resolution was passed at a meeting of the Norwich Medico-Chirurgical Society on Jan. 4th, 1881:—"That this meeting, reprobating the systematic exclusion of the medical officers from the government of hospitals, tenders its sympathy to the staff of Guy's Hospital in the present crisis."

A MEETING of Convocation of the University of London was summoned for Tuesday last, but in consequence of the inclement weather it was decided by the few members present to adjourn the business on the agenda-sheet until the meetings, which will be held as usual, in May.

AT Rome, on the 16th inst., the new Anatomico-Physiological Institute in the Via Quattro Fontane was opened before a numerous and distinguished audience by Professors Tommasi-Crudeli and Moleschott, of whose addresses we shall give some account next week.

THE president, vice-presidents, and council of the Royal College of Surgeons have just issued invitations for a large party of distinguished visitors to the Hunterian festival to be held on the 14th prox. after the delivery of the biennial oration by Mr. Luther Holden.

THE death is announced of Dr. David P. Smith, Professor of Surgery in the Yale Medical School, and one of the most distinguished surgeons in the State of New York.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

THE "METROPOLITAN" AND "THE LANCET."

Our esteemed contemporary, the *Metropolitan*, has taken us to task, in no unkindly spirit, for having spoken somewhat disparagingly of local self-government in the metropolis with reference to small-pox and vaccination. He objects to our phrase, the "genius of muddle," as applied to the local bodies in this respect, and thinks it unwarranted; and he evidently thinks that the hard language which we apply to the Local Government Board for its doings in the present small-pox crisis is irreconcilable with our observations on the local administrative bodies. If, in face of a growing epidemic of small-pox, its own reports of the shortcomings of the vaccination authorities in the East-end, the want of proper co-operation between the vaccination authorities and the sanitary authorities, the state of question as to small-pox hospitals and the relations of the sanitary authorities thereto, our contemporary objects to the term "muddle," we shall not quarrel with him so long as the facts and the causes productive of them are recognised. But our contemporary, we think, furnishes an illustration of our observations last week of people having been led astray from the fundamental element in our means for preservation from small-pox on the by-path of hospital-isolation in small-pox, by the prominence which has been given of late to this question. He had probably not in mind, as we had when we wrote, the primary importance of vaccination as *the* safeguard against small-pox. Now, as far as public vaccination is concerned, the local poor-law authorities are responsible for the due and efficient carrying out of vaccination. In this respect, we gather from the columns of our contem-

porary several of the Boards of Guardians in the East-end of London have been peculiarly remiss in the interval between the last epidemic extension of small-pox and the present. We know well what the difficulties in carrying out vaccination in London are, particularly those enumerated by the Local Government Board; but we draw a somewhat different lesson from them than our contemporary appears to do. These difficulties call for greater and more unremitting care in the administration of the Vaccination Acts in London than they do elsewhere—than in places where they do not exist in the same magnitude; and they involve greater responsibility in the exercise of care. Local self-government has not fully justified itself in the metropolis in this matter, and until the citizens more generally see the grave concern, so far as small-pox is concerned, they have in exacting from their poor-law local representatives a somewhat higher conception of their duties as to vaccination *in the intervals of epidemics* than has hitherto prevailed, we must take our recurring small-pox epidemics, great and small, with such grace as we may.

PUBLIC HEALTH IN SCOTLAND.

The section devoted to public health of the "Thirty-fifth Annual Report of the Board of Supervision for the Relief of the Poor and of Public Health in Scotland, 1879–80," recently published, is devoted to a bare summary account of the particular administrative actions (mainly formal) which the Board has had to undertake during the year, to which the report refers. One of the causes which called for the action of the Board is novel; it refers to the refusal of a sanitary inspector (an equivalent to our inspector of nuisances) to enter a room in which a patient lying ill of "fever" lay, and into which it was presumably necessary that he should enter for the due performance of his duties, on the ground that he did not consider it his duty to do so. On this the Board called for a report from its medical officer, Dr. Littlejohn, on the subject; and observes, "We are aware that in some parts of the country an unreasonable and exaggerated dread of infection is entertained by the population, and we deemed it especially necessary that in places where such feelings exist the sanitary inspector should know what his duties are, and should discharge those duties faithfully. We transmitted a copy of Dr. Littlejohn's report to each local authority for their information and guidance; and we intimated that we were of opinion that every person holding the office of sanitary inspector must be prepared, in the due discharge of his duties, to enter the house or room in which cases of infection exist, as pointed out by Dr. Littlejohn." A copy of Dr. Littlejohn's useful report is given in the appendix to the Board's report.

THE SALE OF FOOD AND DRUGS ACT.

Dr. John Clark has published in a separate form the excellent lecture he gave on "Adulteration and the working of the 'Sale of Food and Drugs Act'" at the opening of the present session of the Glasgow Royal Infirmary School of Medicine. He describes briefly, but clearly, the results of THE LANCET Analytical Sanitary Commission, of the legislation which followed upon them in 1860, and of the various amendments of that legislation to the present time. He illustrates his lecture from the experience of Glasgow, shows the shortcomings in the administration of the Sale of Food and Drugs Act, especially in Scotland, and generally presents us with a readable and most interesting and instructive account of this important subject.

THE HAMPSTEAD SMALL-POX HOSPITAL.

The hearing of the appeal, Hill and others *v.* The Metropolitan Asylums Board, came before the House of Lords this week. The arguments were concluded, but their lordships took time to consider. We reserve comment until the judgment is made known.

A serious localised outbreak of scarlet fever is reported from Halifax, believed (but we learn on insufficient evidence) to be due to dissemination of the contagion of the disease in a milk-supply. A milker, it is reported, had pursued his duties of milking in one of the sources of supply to the implicated dairy while several of his children were suffering from scarlet fever.

The report of Mr. Peter de la Motte of the West London District School for the year 1880 shows on the whole a favourable condition of health among 700 and odd children there, and a comparatively low mortality (7·2 per 1000 per annum). Ophthalmia is spoken of as "the malignant enemy of the school," but is stated to be decreasing under present arrangements. Granular eyelids, however, are reported prevalent, and as requiring constant and careful watching in order to eliminate relapsing cases. The plan of isolating slight cases of ophthalmia is carefully carried out.

From a recent meeting of the Rural Sanitary Authority of the Isle of Wight we gather that the Authority begins to scent trouble from the Local Government Board in its existing arrangements for inspectors of nuisances and medical officers of health. Dr. Ballard's recent visit to the island has no doubt left a pretty clear impression upon the mind of the Authority there that the Local Government Board cannot permit the present arrangements to stand without somewhat peremptory interference. Dr. Ballard's report has not yet been made public.

The Local Government Board take exception to the payment of vaccination officers by fixed salaries, and not by fees per case. The Board state that in their experience the payments of these officers by results has produced the best effects. A proposition of the City of London Union Guardians to give their Vaccination Officer a yearly salary of £75 has not met with the approval of the Local Government Board, and the Guardians have been requested to reconsider the subject, with a view of fixing his remuneration on the fee system.

A Bill has been submitted to the House of Commons by Messrs. Magniac, Dodds, and others, to make provision for the better prevention of floods, and for the conservancy of rivers, but as it is rumoured the Government will bring in a Bill on the subject, we postpone comments until this Bill sees the light.

A Bill has been introduced into the House of Commons by Mr. Edmond Gray and others, to provide for the better Notification of Infectious Diseases in Ireland.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

The unusually severe cold which prevailed during the latter part of last week did not seriously affect the recorded death-rate; the effect of this cold will appear in subsequent returns. In twenty of the largest English towns, estimated to contain in the middle of this year nearly a third of the entire population of England and Wales, 5093 births and 3444 deaths were registered last week. The births were 93 below, while the deaths exceeded by 187, the average weekly numbers during 1880. The deaths showed an increase of 336 upon the low number in the previous week. The annual death-rate, which had been equal to 23·7 and 21·3 per 1000 in the two preceding weeks, rose again to 23·6 last week. During last quarter the death-rate in these twenty towns averaged only 21·5 per 1000, against 25·0 and 24·2 in the corresponding periods of 1878 and 1879.

The deaths referred to the principal zymotic diseases in the twenty towns, which had been 398 and 401 in the two preceding weeks, declined last week to 383; they included 99 from scarlet fever, 90 from whooping-cough, 74 from measles, and 35 from fever, principally enteric. The annual death-rate from these zymotic diseases averaged 2·6 per 1000 in the twenty towns, among which it ranged from 0·7 both in Plymouth and in Newcastle-upon-Tyne, to 3·4 in Bristol and 3·8 in Salford. Scarlet fever showed the largest proportional fatality in Oldham, Norwich, and Bristol; measles in Salford and Brighton; and whooping-cough in Nottingham and Leeds. The deaths from fever (principally enteric) in the twenty towns, which had been 48 and 39 in the two previous weeks, further declined to 35 last week. Of the 19 fatal cases of diphtheria in the twenty towns, 12 occurred in London and 2 in Portsmouth. Small-pox caused 28 more deaths in London and its suburban districts, whereas no fatal case of this disease was recorded in any of the nineteen large provincial towns. The number of small-pox patients in the Metropolitan Asylum Hospitals, which had steadily increased from 77 to 447 in the eleven preceding weeks, further rose to 476 on Saturday last. The new cases of small-pox admitted to these hospitals, which

had been 146 and 85 in the two preceding weeks, rose again to 118 last week. On Saturday last 27 patients were under treatment at the Highgate Small-pox Hospital, showing an increase of 3 upon the number at the end of the previous week.

The deaths referred to diseases of the respiratory organs in London, which had been 290, 353, and 363 in the three preceding weeks, further rose last week to 371; this increase, however, was remarkably small, considering the severe cold, and the number was no less than 111 below the corrected average for the corresponding week of the last ten years; 236 were attributed to bronchitis, and 95 to pneumonia. The annual death-rate from lung diseases (excluding phthisis) was only equal to 5·2 per 1000 in London, whereas in Liverpool the rate from the same diseases rose to 9·1 per 1000, and in Salford it was equal to 13·2.

In the twenty towns last week the causes of 101 deaths were not certified, either by a registered medical practitioner or by a coroner; these were equal to 2·9 per cent. of the total deaths. The proportion of uncertified deaths was equal to 2·0 per cent. in London, while it averaged 3·7 per cent. in the nineteen provincial towns. No uncertified deaths were registered either in Brighton, Portsmouth, Plymouth, Wolverhampton, Leicester, or Sunderland; while their proportion was largest in Norwich, Oldham, Sheffield, and Hull.

HEALTH OF DUBLIN.

The rate of mortality in Dublin again showed an increase last week. The annual rate of mortality from all causes in the city, which had been equal to 35·8 and 31·8 in the two preceding weeks, rose again to 35·1 last week. During last quarter the death-rate in the city averaged no less than 32·6 per 1000, against 20·9 in London and 21·8 in Edinburgh. The 224 deaths in Dublin last week showed an increase of 21 upon the number in the previous week, and included but 12, or little more than 5 per cent., which were referred to the seven principal zymotic diseases; the number of deaths from these diseases in the previous week was 28. The 12 deaths from zymotic diseases in Dublin last week included 8 which were referred to fever (comprising typhus, enteric, or typhoid, and simple continued), and a fatal case each of small-pox, scarlet fever, whooping-cough, and diarrhœa; no death resulted either from measles or diphtheria. The annual death-rate from these zymotic diseases did not exceed 1·9 per 1000 in Dublin last week, while in London it was equal to 2·9, and in Edinburgh 4·0; so low a death-rate from zymotic diseases in Dublin has not occurred for many months. The deaths referred to fever in Dublin, which had steadily increased from 7 to 13 in the four previous weeks, declined to 8 last week; these, however, were equal to an annual death-rate more than five times as high as the average rate from the same causes last week in the twenty large English towns. The deaths of elderly persons (aged upwards of sixty years) in Dublin, which had been 43 and 47 in the two previous weeks, further rose to 66 last week.

GROWTH OF POPULATION IN ENGLISH TOWNS.

Within three months the Census of 1881 will have been taken, and before the end of June we shall know with some approach to accuracy what is the present population not only of the whole country, but also of its chief towns. In the mean time, however, the Registrar-General has been at the necessity of estimating the population of our large towns to the middle of 1881, for the purpose of calculating the annual rates of mortality published in the Weekly and Quarterly Returns. It is needless to say that these estimates are based for the most part upon the assumption that the rate of increase of population since 1871 has been the same as that which prevailed during the ten years 1861–71. The estimated population of the twenty towns, in the middle of this year, amounts to more than seven and a half millions of persons, and exceeds by nearly 120,000 the estimate for the middle of 1880. The excess of births over deaths in these twenty towns during last year was scarcely more than a hundred thousand, and it becomes a matter of conjecture whether the population in these towns was raised during the past year of commercial depression by the aggregation of nearly 20,000 immigrants. The probability is that the Census returns for many of our large towns will show that the increase of population during the decade just ended has been at a lower rate than that which prevailed in the preceding ten years; this would cause the Registrar-General's estimates of their present population to be in excess of the true numbers. In Sheffield, for instance, based upon the rate of increase during the ten years 1861–71, it is estimated that the gain to the population during 1880 was more than 8000, of which little more than 4000 is accounted for by excess of births over deaths. Those who know the severe period of depression from which Sheffield has recently suffered will scarcely be inclined to believe that the population of that borough was increased by nearly 4000 persons during 1880 through the excess of immigration over emigration. The population of Bristol and of some other towns is probably also over-estimated from the same cause. These doubts will be set at rest by the approaching Census, but it is much to be regretted that the value of the vital statistics for our largest towns, which are very properly attracting increased attention year by year, should be depreciated by the want of more trustworthy information as to population than can be derived from a decennial Census.

HEALTH MATTERS GENERALLY AT HOME AND ABROAD.

THE SEWAGE OF PARIS.

Dr. Guéneau de Mussy has presented to the Society of Public Medicine of Paris, in the name of a commission of the Society, a report on the removal of night-soil from the habitations of Paris. The report recommends that it be made obligatory to introduce a water-supply into each house proportionate to the number of occupants; that properly constructed *cabinets d'aisance* should be required; that water should be readily accessible in the *cabinets d'aisance*; that wherever possible the *cabinet d'aisance* should communicate directly with a sewer; that where this is not practicable a movable receptacle should be had recourse to with a disinfectant to accompany each dejection; and, lastly, that "alopa," as dejections, should pass directly to the sewers, a syphon-trap intervening. All the recommendations but that relating to "alopa" were adopted by the Society. The modesty of the recommendations give a remarkable illustration of the shortcomings of Paris in these matters.

The Committee appointed by the Municipality of Paris to consider the question of the recent offensiveness of odour in the streets of that city, formed two sub-committees to consider respectively the question as it concerned sewers and cesspools (fixed and movable), and as it concerned depôts of offensive filth and manufactories concerned with the filth. The second sub-committee has reported, M. Aimé Girard, member of the Consultative Committee of Arts and Manufactures, acting as reporter. The recommendations of the sub-committee would do away with all depôts of filth within the city and its suburbs, and would subject to strict regulation the manner of dealing with filth in manufactories and the effluvium from the filth, so as to withdraw it from the free air, deodorise the solid matters, and destroy by fire offensive vapours.

PUBLIC HEALTH IN AUSTRALIA.

Although Australia has hitherto escaped the infection of cholera, it has not escaped the infection of Congresses. Melbourne has been having its "Social Science Congress," and, after the fashion of the home-bred examplar, a "health section" formed an integral portion of the Congress. According to our contemporary, the *Australian Medical Journal*, this section fell far short in its proceedings of what it had projected to do, and did not compare well, whether in material or in the exhibition of business capacity, with other sections. The address of the President, Dr. M'Crea, was not of a sort to put good heart into the meetings, and if, as he argued, the pioneers of public health in the Old World took a too warmly-coloured view of the public advantages to be derived from sanitary works and the labours of sanitary workers, he erred in the opposite direction in taking a too desponding view. It should have been obvious to him that his reference to the mortality statistics of Great Britain, and the vast expenditure of money in the last forty years, and the asserted inappreciable results therefrom, bristled with fallacies. A very different picture might have been drawn of the results of sanitary work in this country, at least equally free from too great hopefulness or too great despondence, and which would have given heart to the efforts now being made for the sanitary administration of Melbourne, and furnished the reasonable grounds upon which such efforts should be

based, and which justify and incite Great Britain to add other millions to the millions already expended in the sanitary works and administration of the United Kingdom.

FEVER HOSPITAL FOR EDINBURGH.

No fever hospital worthy of the name exists at present in Edinburgh. It is true that the Infirmary managers, by arrangement with the Town Council, provide seventy-two beds in the old infirmary buildings for the accommodation of fever patients, no cases of this nature being treated in the new infirmary; but while this provision just serves to meet the requirements of the city for the moment, there being now sixty-five fever patients under treatment, it would prove very inadequate should an epidemic of even moderate dimensions break out, an event for which no great city can afford to be unprepared. A proposal has lately been made to purchase definitely the old infirmary buildings and convert them into a hospital for the treatment of infectious diseases. Many are of the opinion, however, that such hospital accommodation should be erected outside the city. Meanwhile Dr. Littlejohn, the medical officer of health, is preparing a report on the whole subject, which will soon be made public. This is clearly a matter which the Local Authority should undertake, as the Royal Infirmary has no funds of its own available for the purpose.

Diphtheria is reported to be raging at Mohilev, in Podolia. The Red Cross Society has organised seven sanitary detachments to meet the epidemic, each detachment consisting of a physician, two sub-surgeons, two sisters of charity, and numerous assistants.

Animal lymph has been introduced into Madras, and a regular depôt has been established, for the maintenance of which the Government has sanctioned a monthly allowance of 100 rupees.

Small-pox is stated to have broken out in the General Hospital of Halifax, Nova Scotia, and the majority of the patients in one ward had been attacked by the disease.

THE SERVICES.

MEDICAL REINFORCEMENTS FOR THE TRANSVAAL.

In addition to the medical officers who are now on their way to the Cape, to strengthen the staff at the disposal of Deputy Surgeon-General Holloway, C.B., the Indian authorities have detailed twelve officers of the Army Medical Department to accompany the troops embarking at Bombay for service in the Transvaal. These should reach Durban, the port of disembarkation, early in February, and will be a welcome addition to the medical staff.

Brigade-Surgeon William Skeen, M.D., and Surgeon Espine C. R. Ward are with the force under Sir Owen Lanyon, at Prætoria.

Brigade-Surgeon Sampson Roch was unable through ill health to proceed to the Cape last week, for service in Natal.

Deputy Surgeon-General J. Crerar succeeds Deputy Surgeon-General J. B. St. Croix Crosse as medical officer of the Royal Military Asylum at Chelsea. Dr. Crosse having attained sixty-five years of age is placed on the retired list.

ADMIRALTY.—In accordance with the provisions of Her Majesty's Order in Council of Feb. 22nd, 1870, Surgeon William Sale Sandham has been placed on the retired list from the 7th inst. The following appointments have been made:—Staff-Surgeon Bradley Gregory to the *Druid*, vice Bett, deceased; Staff-Surgeon A. B. Trousdell, M.D., to the *Phœnix*, vice Gregory; Surgeon Henry Scanlan, to the *Rifleman*; Surgeon Robert M'Ivor, M.D., to the *Asia*, vice Scanlan.

THE Metropolitan Hospital Sunday will be June 19th; February 7th and 13th are fixed as the Hospital Sunday and Saturday for the Manchester and Sheffield medical charities; the 9th inst. will be the Liverpool Sunday Fund; and on the 30th collections will be made in all the churches in Sheffield and the neighbourhood for the local medical charities.—*Charity Record.*

Correspondence.

"Audi alteram partem."

AN EXPLANATION OF THE NATURE OF THE CONNEXION BETWEEN THROAT AFFECTIONS AND ACUTE RHEUMATISM.

To the Editor of THE LANCET.

SIR,—In his paper on the "Association of Affections of the Throat with Acute Rheumatism" (THE LANCET, Dec. 11th, 1880), Dr. Fowler offers no theory to account for the undoubted connexion between the two, further than to state that it is not "to be explained on the hypothesis of a merely casual connexion," and that he believes "that not unfrequently it [the tonsillitis] is an early manifestation of the same [rheumatic] diathesis."

Pending the publication of a paper which I have in course of preparation upon the same subject, in which I have independently observed the same fact during the last few years, I would like to point out briefly that *all rheumatic fever cases* are, in my opinion, of truly pyæmic origin. By adopting this theory, which to me seems the true explanation of its nature, both from a clinical and pathological point of view, we can at once understand why a suppurative affection of the throat is followed by so-called rheumatic fever.

My experience accords pretty closely with Dr. Fowler's in placing the proportion of cases of acute rheumatism preceded by an affection of the throat at from 70 to 80 per cent., and it follows most frequently, if not only, upon the throat affection, that may be called, for want of a better name, acute follicular tonsillitis, in which a kind of purulent exudation is formed in the tonsil, and struggles out through the follicular openings on its surface.

By the prevention of its free exit, absorption of the pus is facilitated through the lymphatic vessels passing between the tonsil and the lymph gland at the angle of the jaw. The lymphatic gland resents this intrusion, inflames, enlarges, and endeavours to arrest the passage of the poisonous material in its onward course to the blood. In the discharge of this function the gland is sometimes completely successful, and hence many cases (though the first step towards infection of the blood is taken) never produce the affection of the joints or other organs. In other cases this function of the gland is less completely successful; the gland being unable to render the absorbed pus innocuous, or extrude it by inflammation, it passes onward to join the general circulation, after being arrested in its passage for a period of from one to three or four weeks, or, as I have some reason to think in some rare cases, for a considerably longer period; whilst in other cases still, that occur in constitutions of a more lymphatic diathesis, in which the lymphatic vessels may be wider or more active in their absorptive powers, or the glands less discriminative or resentful of the intrusion of effete or poisonous matter, the blood infection is accomplished, if not *pari passu* with the throat affection, at a very short interval after its declension.

The remaining 20 to 30 per cent. of acute rheumatic cases which do not claim this particular origin, may be brought about by absorption of pus elements at other mucous membranes, such as in the ear in acute or chronic otorrhœa, in the urethra in acute or chronic gonorrhœa, at the anus (as in fistula); and failing these particular localities, the absorption of any collection of pus, however small and apparently trivial, situated either in the mucous lining of organs, or on the cutaneous envelope of the body, is sufficient, in my experience, to accomplish the same result.

The last case I attended followed upon a small abscess under the finger-nail, the whole of which was absorbed, to be followed at the interval of a fortnight by affections of both ankles, knees, wrists, and the right shoulder in succession, producing what would be called a typical case of rheumatic fever.

Thus it will be seen that absorption of pus elements may take place in localities very likely to be overlooked, at least so far as its connexion with the after-production of rheumatic fever is concerned, and this occurrence not being

followed *immediately* by the usual symptoms of purulent infection of the system, but the after sequences following at a considerable interval in point of time, easily accounts for the connexion between the two, which is really of a *post hoc, propter hoc* nature, remaining thus far unrecognised.

My experience further goes to prove that following upon the absorption of the throat, or at the other localities indicated, the absorbed *materies morbi* in passing the round of the circulation may entirely miss the joints, and the force of the poison may then spend itself upon other fibrous and connective tissues, such as the parenchyma of the liver, producing icteric complications; of the lungs, producing patches of consolidation; upon the fibrous envelope of the heart and its valves, causing pericarditis and endocarditis; and more rarely upon the fibrous covering of bones, causing thickenings of the periosteum, and even necrosis of bone. As a result of this absorption any one of these sequences may occur separately in a given case, or any two or all of them may be combined together in the same case. Sometimes one joint only is affected, at others all the joints and the heart as well. I have also observed a few joints, the liver, and the heart attacked, on other occasions the liver and the lungs; and even the heart only, producing what might have been called idiopathic carditis; and in a rare case I have known the joints, the liver, the lungs, the heart, and spleen all involved.

In conclusion, I would remark that the beneficial action of such remedies as alkalies, salicylates, iron, &c., in rheumatic fever, goes far to render probable the truth of the theory that pus cells (modified or unmodified) in the blood is its real cause, and that by adopting this theory the beneficial action of these remedies is, I think, placed upon a more scientific basis.

I am, Sir, your obedient servant,

WM. STEWART, F.R.C.P.E.,

Barnsley, Dec. 21st, 1880. Honorary Surgeon, Beckett Hospital.

CHIAN TURPENTINE IN CANCER.

To the Editor of THE LANCET.

SIR,—I trust you will allow me space in your valuable journal to call the attention of your readers to the following case, in which Chian turpentine was administered daily for nearly four months with marked benefit, as shown by the relief obtained from all distressing symptoms, and in the fact that the poor sufferer's path to the grave was deprived of pain. In justice to Prof. Clay, I feel bound to record my experience.

Mrs. C——, aged fifty-four, the mother of a large family, consulted me in August last. She informed me that about five years previously a "tumour" (probably cancerous) had been removed from the top of her head by Mr. Pridgin Teale of Leeds. A year and a half after the operation she noticed that a similar growth was forming behind the right ear. This had gone on increasing in size until the time she put herself under me. On making examination I found she was in a frightful condition. There was a medullary cancer of a fungoid type behind the ear, about the size of a hen's egg. It had begun to break down, and there was a very great discharge of pus and blood; from the base of the ulcerated portion cauliflower-like growths were springing. The right side of the face was very œdematous, the eyelids so swollen that she could not open the eye. All the lymphatics of the neck, thorax, and right arm were thoroughly infiltrated with cancerous matter, and over the upper part of the sternum was a large suppurating patch the size of the hand. She had a severe cough, and expectorated pus freely, often dreading lest she should be suffocated. Her general health was quite broken down. Slept badly; appetite poor; suffered much pain, especially in the neck and chest; very weak; had much palpitation. I gave her relatives an unfavourable prognosis. Treatment adopted: a five-grain pill of Chian turpentine (made according to Prof. Clay's formula) three times daily, after meals. Finding that she could take this quantity well, at the end of three weeks I increased it to double—viz., two pills three times daily. I also prescribed a mixture containing in each dose three minims of solution of strychnine and five minims of solution of perchloride of iron twice daily, as suggested by Prof. Clay. She improved in general health, felt so strong that she was able to visit me until within five days of her death. Her appetite increased, and she was able to take plenty of nourishment. She slept well most of the night, lost the palpitation and suffocative breathing, and, most remarkable and pleasing of all, the pains left her and never returned. All her friends considered the last result of the treatment to be marvellous. The turpentine never produced nausea or diarrhœa. The local symptoms on the whole remain unchanged.

Now I am persuaded that this poor woman's life was prolonged and her sufferings relieved by the use of the Chian turpentine. I never expected to cure her, as all the lymphatics were so thoroughly affected. If, however, the case had been treated four or five years previously by the above method there would perhaps have been no return of the disease. Even supposing Prof. Clay has not introduced a remedy which will cure cancer, yet if a sufferer's life can be prolonged and all distressing symptoms removed and death robbed of terror and pain, surely he has done something to earn the gratitude of the profession and the public! Meantime I would advise a still more extended trial of this remedy.

I am, Sir, yours truly,

Leeds, Jan. 10th, 1881. H. A. ALLBUTT, M.R.C.P.E.

STATISTICS OF OVARIOTOMY.

To the Editor of THE LANCET.

SIR,—Although it may be, as a rule, undesirable to refer in your columns to statements made in the discussions which take place at any of our Societies, yet there are occasions when there is no escape from such a course for the sake of truth and justice. Such a one is the present.

At the last meeting of the Royal Medical and Chirurgical Society I submitted to the judgment of my professional brethren a question of professional etiquette. After referring to the fact that, at a former meeting, Mr. Thornton quoted my results in ovariotomy in the Samaritan Free Hospital for the year 1880 for the purpose of comparing them with his own, I used these words: "I think it is a most unusual proceeding, and one that, I am sure, will not meet with your approval, but rather deserves to be censured, when anyone refers to the statistics of a colleague before they have been published either by the hospital or by the operator himself." To this Mr. Thornton is reported by you to have replied that "the statistics he then quoted from Dr. Bantock had been *mostly* (the italics are mine) published by that gentleman in a letter to one of the medical journals." As I was obliged to leave the meeting almost immediately after I had spoken, I did not hear Mr. Thornton's remarks, and, therefore, now ask him, through you, for the reference to the particular letter on which he relies. I wish to put myself right with those of my professional brethren who may have read your report, but more especially with the Society, whose guest I had the honour and privilege of being on that occasion.

I am, Sir, your obedient servant,

GEO. GRANVILLE BANTOCK.

Granville-place, Portman-square, W., Jan. 15th, 1881.

THE NEW FORM OF GAG.

To the Editor of THE LANCET.

SIR,—Will you kindly allow us, in your next issue, to explain the reason why we claim any credit for the "improved ring catch," in Mr. T. Smith's new combined mouth-gag and tongue-depressor. Mr. Rose was certainly kind enough to leave with us one of his gags as a pattern; but the gag was found unnecessarily long, and projected from the mouth, so as to be inconveniently in the way in operating, and on any side movement of the patient's head against the pillow being unexpectedly made, it was likely to be knocked from between the teeth. To do away with the likelihood of this occurring we have made the *levers* or *arms considerably shorter*, and with a larger space between them; this has been found a great advantage, as there is no *loss of power*. This alteration required a different arrangement of the catch than that of Mr. Rose's, which is simply a ring passing over the plain steel arms, the contact with the plain metal surface only preventing slipping. To our gag, therefore, we added a series of notches, or hollows, into the catch, thus doing away with any possibility of any slipping, and the gag unfortunately collapsing during an operation. We

shall be happy to show the advantage of the gag to anyone calling, or it can be seen in use at the Children's Hospital.

As regards Mr. Rose's remarks regarding the utility of the tongue-plate, Mr. Smith informs us, "that it answers exactly in depressing the tongue, leaving nothing more to be desired in the many cases it has been tried, and is sure it will be found satisfactory in mouth operations."

We are, Sir, your obedient servants,

Great Portland-street, Jan. 19th, 1881. MAYER & MELTZER.

To the Editor of THE LANCET.

SIR,—Mr. Rose objects to the addition of the tongue-plate in Mr. T. Smith's new form of gag (for use in removal of tonsils and in staphyloraphy) on account of its being liable to cause inconvenience when an anæsthetic is used. In the operation for the removal of tonsils, where an anæsthetic certainly is not required, I have never found a gag desirable. A child does not generally give trouble in the removal of one tonsil if there be no previous display of instruments, and should it tightly close its mouth during the very short time occupied in putting the guillotine in order for the second tonsil, it is only necessary to compress its nostrils, and immediately the mouth is opened to push the instrument in sideways; then turning it round one has a gag and at the same time the guillotine in position. In this way and with a good light a troublesome child's tonsils take very little over the ordinary time of eight seconds for removal.

I am, Sir, yours faithfully,

W. PUGIN THORNTON.

Devonshire-street, Portland-place, Jan. 14th, 1881.

THE FELLOWSHIP OF THE EDINBURGH COLLEGE OF SURGEONS.

To the Editor of THE LANCET.

SIR,—It is time that public attention was drawn to the disgraceful traffic going on in this sham qualification. Time was when it was given to a few, and conferred at least a social distinction in Scotland, and when the income of the college was but slightly enhanced by it. Now I am told they draw about £2000 a year from this source alone. This town and district are being flooded by the bogus distinction, and its holders sign themselves "F.R.C.S." or "F.R.C.S.E.," thus leaving it to be inferred that they are Fellows of the London College. It is getting as bad as the "L.R.C.P." of 1859, and can be stopped in the same way, by an expression of professional opinion.

I am, Sir, yours truly,

Birmingham, Jan. 15th, 1881. F.R.C.S. ENG. (EXAM).

To the Editor of THE LANCET.

SIR,—I fear the statements respecting the regulations in force at the Royal College of Surgeons of Edinburgh alluded to by your correspondent, a "Disinterested Medical Reformer," in THE LANCET of the 15th inst., are substantially correct.

The present regulations of the College as regards its Fellowship are a great injustice to the interests of the profession, to its own acknowledged respectability, and to those of its Fellows who have, like myself, many years since obtained the diploma by regular examination. I trust the Royal College will see reason to make such alterations in its rules as will restore its prestige.

Believe me, Sir, yours faithfully,

A FELLOW BY EXAMINATION OF

Jan. 17th, 1881. 25 YEARS' STANDING.

PRELIMINARY EXAMINATIONS OF THE ROYAL COLLEGE OF SURGEONS.—The Council of the Royal College of Surgeons has just given notice that from and after the 31st of December next these examinations for the diploma of Fellow and Member of the College, at present conducted by the College of Preceptors, under the authority of the College, will cease, and that from and after the date of this notice candidates for the diploma of Fellow will not be required to undergo any preliminary examination beyond that required for the diploma of Member of the College.

GLASGOW.

(*From our own Correspondent.*)

GOVANHILL, a burgh on the outskirts of Glasgow, has at length secured the services of a medical officer. His duties are that "he should consult with the magistrates and officers of the burgh in all matters requiring a medical opinion, make examinations, submit reports, and attend courts when required, at a salary of *twelve pounds* per annum, the engagement to be terminable on a month's notice on either side." Well might one of the Commissioners present make the remark that he "could scarcely think that any medical gentleman would be willing to accept such an amount of work at such remuneration." The circumstances under which Dr. A. J. Hall, the previous holder of this office, surrendered his appointment are sufficiently remarkable, and should be known to every health officer in the country. Dr. Hall worked for three years as "medical officer of the burgh of Govanhill," imagining that his appointment was under the Public Health Act, a view in which he was supported by the fact that the authorities, in their annual returns, represented his salary as paid under that Act. In the course of last summer, however, he was asked to examine and report in a case of assault; this he did, and charged a small fee. The Commissioners agreed to pay this fee, but intimated that in future no such extra charges would be allowed. The Board of Supervision decided, after some correspondence had passed, that the differences of opinion to which these circumstances had given rise could be settled only in a court of law. The burgh of Govanhill thus appears before the professional public in a very discreditable light; they ask an officer, whom they employ in their capacity of local authority, to perform the duties not only of medical officer under the Public Health Act, but also of police-surgeon, the Police Act being one of a separate nature, and one for which a special tax is levied. They do this with their eyes open, as witness the statement made by their clerk at a recent meeting. Mr. Robertson Sair, in reference to the proposal that, in advertising for a new officer they should specify his duties, said "that it was dangerous to enter into particulars. Their last engagement was drawn in such an indefinite way that they could scarcely conceive any duty which it would not cover."

IRELAND.

(*From our own Correspondent.*)

THE outbreak of fever in Tandragee, county Armagh, to which you alluded last week, has attracted considerable attention, and as I have received reliable information on the subject, a few remarks may not be out of place. The epidemic, it appears, broke out on the 10th December last, and since then 120 cases have occurred; the cause of the outbreak being the contamination of one of the water supplies of the town with dejections from a typhoid patient who was first seen by the medical officer of the district three days after the outbreak in an almost convalescent state. The excretions of this patient were thrown into a small river which at flood-time communicates with the water-supply above referred to, and in this way the disease was spread. Dr. James Taylor, the medical officer of the district, had the water-supply cut off on the 13th December, and only three fresh cases occurred during the week ending the 13th instant. The number of cases which took place since the epidemic broke out, as relieved by the dispensary, is as follows: First week (10th to 17th December), 22 cases; second week, 38; third week, 31; fourth week, 26; fifth week, 3. Thirteen deaths had taken place up to the 13th inst., and not seven, as mentioned by Mr. Forster, Chief Secretary for Ireland, in reply to Mr. E. D. Gray's question in the House of Commons last week.

The Registrar-General for Ireland has made two changes regarding the areas adopted in his returns for the Dublin Registration District. The area has now been extended so as to embrace the registrars' districts of Clontarf and Howth No. 1, Coolock and Drumcondra No. 1, and portions of the districts of Finglas and Glasnevin and Palmerston. The other change relates to the provincial town districts, for which statistics are given, and consists in the substitution of

the "Urban sanitary district" for the "Registrar's district," or group of Registrars' districts. These changes have been made with the view of supplying more accurate information regarding the mortality in towns; and, I may add, with the hope of reducing the city death-rate by including in the Dublin Registration District outlying regions whose inhabitants possess a higher standard of health.

Dr. Cameron, President of the Metropolitan Officers of Health Society, at a meeting held at the Royal College of Surgeons last week, delivered the annual address. He stated that the death-rate of Dublin, which during the decade ended in 1877 was 26·2 per 1000 persons living, rose in 1878 to 29·5, and in 1879 to 34·6 per 1000, and continued at the latter high rate in 1880. It was difficult to account for the marked increase in 1879–80, unless it was the result of the destitution which existed in the city during these years, caused by the bad harvest, which reacted upon the town population. The increase in the registered deaths in 1879–80 was to the extent of about 10 per cent., accounted for by the fact, that in these years the registration was corrected by means of returns from the cemeteries, for before 1878 it was found that, owing to defective registration, the burials exceeded the registered deaths by 11 per cent. Making every allowance, however, the increase of registered deaths was in 1879 15 per cent. over the average of the ten previous years. The increase was not due to the greater prevalence of zymotic diseases, compared with the other classes of maladies, all kinds of disease showing an increase. The causes of the high death rate may be attributed to the bad tenement dwellings, the existence of slaughter-houses and dairy-yards in crowded localities, the prevalence of much poverty and intemperance amongst certain classes, and the relatively larger proportion of the poorer classes which distinguish Dublin from English towns. The condition of the tenemental dwellings was very bad, but an improvement in them is being effected, there having been 604 houses unfit for habitation and 197 cellar dwellings detenanted and closed between August 1st, 1879, and Dec. 31st, 1880.

Dr. J. W. Busteed of Tralee has been placed on the Commission of the Peace for the County Kerry.

The annual general meeting of the Dublin Branch of the British Medical Association will be held at the College of Physicians in Ireland on the 27th inst., when the President, Dr. Robert McDonnell, F.R.S., will deliver an address.

PARIS.

(From our own Correspondent.)

A MOST promising young physician, Dr. André Poulin, met with his death last week under very painful circumstances. The *concierge* of the house in which he resided had received notice from the landlord to quit, and suspecting Dr. Poulin of having been instrumental in obtaining his dismissal, he determined to have revenge. The delay which had been granted to him to obtain another situation would have expired on the 15th of January, but two days before he put his long premeditated project into effect. Concealed in a bedroom which has a small window commanding the principal staircase, the murderer quietly sighted his victim as he was leaving his apartment at ten o'clock in the evening, in company with several guests, and discharged the contents of one barrel of his gun, wounding him mortally in the groin. The contents of the second barrel were distributed amongst those who had come to the rescue. Dr. Poulin had only recently completed his medical studies and obtained his degree. He had been house-physician for four years at the Paris hospitals, terminating as prize medalist a brilliant curriculum. He was a member of the Anatomical and Clinical Societies, and had been named a short time since to the important post—the first step to the Professorate—of *chef de clinique*, under Professor Hardy.

The death returns of Paris show a great increase of mortality for the last week, which is mainly due to typhoid fever, of which ninety-five cases terminated fatally. This is very nearly four times as much as the average of the corresponding weeks of the last four years (twenty-two), and half as many again as during the preceding week (sixty-three). Pulmonary diseases of all kinds also gave an increased mortality, which brings up the total to 1185, a figure which represents an annual death-rate per 1000 of 30·1.

M. Landrieux, of the Hôpital St. Louis, made a communication to the Société Médicale des Hôpitaux concerning five Esquimaux whom he had recently occasion to treat for small-pox. Of these two died before the period of eruption with hæmaturia, two more died after the exanthem, which was confluent and hæmorrhagic, had appeared. Neither of the patients had been vaccinated. On post-mortem examination the livers and mesenteric ganglia were found to be much hypertrophied, a condition which depended upon the fatty nature of the food used during life.

A discussion has been carried on at the same Society on the Effects of Ear-piercing in Scrofulous Subjects. From a large number of cases quoted by different speakers, it would appear that this trifling operation, usually performed by the jewellers, is often followed by disagreeable consequences. In a strumous person it very frequently sets up ulceration, which persists as long as the earring is worn, and ends by a fissure of the lobule. At other times a troublesome eczema is produced, which cannot always be cured by the removal of the exciting cause.

Dr. Seure has published a memoir which was presented some six months ago to the Academy of Medicine, on the Electric Properties of Dried Collodion. He finds that thin leaves of this substance, which may be detached from glass or metal plates, are negatively electric in the very highest degree, sulphide of copper and gutta-percha being positive in respect to them. In the dark they become luminous by friction, and when rubbed with the fingers they give rise to a sensation of numbness. If the outside of a bottle be covered with collodion, and then rubbed, small sparks can easily be obtained. Dr. Seure thinks that some therapeutic effects may be obtained from this substance. He suggests that leaves of dried collodion should be sewn on the inside of the garments worn by hemianæsthetic subjects, or that they should wear under-sleeves or leggings of collodionised silk. Hemianæsthesia is such a refuge for destitute therapeutic methods that it would be almost a pity to commence operations there. If collodiono-therapy is really an efficient means of applying static electricity, there are other conditions in which it might be tried. Its "æsthesiogenic" power can always be fallen back upon as a last resource.

An ingenious philanthropist proposes to diminish the mortality amongst the wounded in war by tattooing on the soldiers' bodies the principal points where compression may be made in cases of hæmorrhage. Life may be lost in a few minutes by a wound of a large artery, and it is thought that the soldier might often escape if he knew where to command an artery whilst waiting for help.

MEDICAL NOTES IN PARLIAMENT.

IN the House of Commons on Thursday, 13th inst., a petition was presented from Thomas Robinson for inquiry into the East India Medical Service. The Medical Appointments Qualifications Bill, brought in by Mr. Errington and Mr. A. Moore, was put down for second reading on the 20th.

On Friday, upon the motion of Mr. Secretary Childers, the select committee on the Contagious Diseases Acts was appointed in the following terms:—"To inquire into the Contagious Diseases Acts, 1866–1869, their administration, operation, and effect:" Mr. Massey, Mr. Stansfeld, Mr. Cavendish Bentinck, Colonel Alexander, Viscount Crichton, Mr. Burt, Mr. O'Shaughnessy, Mr. Osborne Morgan, Mr. Cobbold, General Burnaby, Sir Henry Wolff, Mr. Ernest Noel, Colonel Digby, Mr. William Fowler, and Mr. Hopwood. Power to send for persons, papers, and records; five to be the quorum. Ordered, that all reports and returns relating thereto be referred to the said committee; that it be an instruction to the committee that they have power to receive evidence which may be tendered concerning similar systems in British Colonies or in other countries, and to report whether the said Contagious Diseases Acts should be maintained, amended, or repealed. A Government Bill to revise the constitution of endowed schools and hospitals in Scotland was brought in by Mr. Mundella.

On Monday, in reply to Mr. H. B. Sheridan, Mr. Courtney (the new Under-Secretary for the Home Depart-

ment) stated that it was not intended to recommend the remission of any portion of the sentence passed upon the chemist Titley. Further petitions for inquiry into the Medical Service of the Indian Army were presented from Thomas Beaumont and George Burn. According to the order-book of the House of Commons, as printed on the above day, the second reading of the Medical Appointments Qualification Bill is fixed for the following Thursday; the Endowed Schools and Hospitals (Scotland) Bill stands for second reading on the 27th instant; the Medical Act 1858 (Amendment) Bill is the first order for Wednesday, February 2; Mr. P. A. Taylor's anti-vaccination motion has the first place for Tuesday, Feb. 8; the Infectious Diseases Notification (Ireland) Bill stands for Wednesday, March 30th; Mr. Dillwyn's Lunacy Law Amendment Bill is put down for Wednesday, May 25th; and the Contagious Diseases Acts Repeal Bill is fixed for second reading on June 15th. The following is the text of Mr. Cubitt's notice for which no day has yet been fixed with regard to London fogs:—"To move for the appointment of a Select Committee to consider to what extent the fogs of London are injurious to life, health, and property; whether they have increased and are increasing from causes which are controllable; whether the existing Acts of Parliament relative to the consumption of smoke are applicable to the present state of the metropolis, and can still be enforced; and whether alteration and extension of this legislation would be beneficial."

On Tuesday, the Government withdrew their Endowed Schools and Hospitals (Scotland) Bill, and a fresh Bill was introduced, "To Reorganise the Educational Endowments of Scotland." The second reading of the River Floods Prevention Bill was deferred to Tuesday next. Mr. Healy gave notice that he would ask leave to introduce a Bill to amend the law relating to coroners in Ireland. Mr. Moore gave notice of a question as to the production of the evidence taken at a recent inquiry by Inspectors Bourke and Brodie at Belfast Workhouse.

On Wednesday, a petition was received from C. E. Raddock for inquiry into his case. A Bill for the Appointment of a commission on local boundaries was brought in by Lord E. Fitzmaurice. Mr. Sexton gave notice that he would move for particulars of a recent inquiry at Dromore Workhouse.

On Thursday, Mr. Warton asked the Secretary of State for the Home Department whether it was the fact that, acting under the advice of the Lunacy Commissioners, such advice being supported by the report of a medical superintendent of asylums, he declined to sanction the enlargement of the Joint Counties Asylum at Abergavenny; whether he did not subsequently reconsider his decision, being influenced so to do by the advice of Dr. Gover, the Medical Inspector of Prisons; and, whether the recommendation of the Lunacy Commissioners was set aside in consequence of the opinion of a medical man unconnected with their body. Sir W. V. Harcourt said the facts were these: The Committee of Visitors wanted to enlarge the asylum. The Commissioners in Lunacy thought there ought to be a new building on a new site. It was left to the Secretary of State to settle the point; and when he (Sir William) came into office he carefully investigated the matter. It was finally reported to him that, although a new building on a new site would be ideally the most perfect thing, still an additional building on the old site would do well enough; and the consequence was that he declined to force the local people to go to an unnecessary expense. He desired to add that, with the present heavy burden of the rates, he did not wish to use the central authority to compel the local authorities to enter into expenditure which they felt to be unnecessary, and which could not be proved to be necessary. Mr. Errington asked the Vice-president of the Council whether he would agree to the appointment of a Select Committee to continue the inquiry commenced in 1878 into important questions of medical reform. Mr. Mundella stated that last year there was a Medical Bill of the Government before the House. It was referred, with other Bills, to a Select Committee. The Government did not see any probability of a Medical Bill being discussed and receiving proper attention this session, and they therefore had no intention of introducing such a Bill. But they thought it probable that some advantage would result from a continuation of the inquiry. The whole question was under consideration, and he would confer with his hon. friend about it.

Obituary.

WILLIAM ALEXANDER WHITE, M.D.

THE death of Dr. W. A. White, late of the Army Medica Service, is announced as having occurred at Duncan-street, Edinburgh, on the 29th ult. Dr. White, who was a graduate of Edinburgh, obtained his commission as an Assistant Surgeon on the 18th October, 1853, and was shortly afterwards gazetted to the 47th Regiment, with which corps he served in the Mediterranean and throughout the Crimean Campaign, including the battles of Alma, Balaclava, Inkerman, and the Fall of Sebastopol (medal and three clasps and Turkish medal). He was promoted staff-surgeon in May, 1863, and was appointed to the Royal Artillery in January, 1864, serving in charge of a brigade in India for several years. He became Senior Surgeon-Major in 1873, and did duty in Dublin prior to his retirement in October, 1879, on half-pay, when he was granted the honorary rank of deputy surgeon-general. Dr. White was unmarried.

SURGEON-MAJOR WILLIAM IRONSIDE.

WE regret to announce the death on the 16th instant, in Edinburgh, of Surgeon-Major William Ironside, M.D., of the Army Medical Department. Dr. Ironside studied at Aberdeen, of which University he was a graduate, and entered the Army as an Assistant-Surgeon on the 1st April, 1861. He was shortly afterwards gazetted to the 71st Highland Light Infantry, with which regiment he served several years in India, being transferred to the Royal Artillery on the reduction of the junior assistant-surgeons of regiments in India. He was promoted Surgeon-Major in April, 1876, returned from a tour of service in India in 1878, and had been stationed in Edinburgh for the last two years. He leaves a widow and two children to mourn his loss.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the required examination for the diploma, were duly admitted Members of the College at a meeting of the Court of Examiners on the 18th inst.:—

Carter, D'Arcy Bainbridge, Leeds.
Clarke, Walter James, Birmingham.
Evans, Thomas Jones, Llanybyther, Carmarthen.
Holt, William, Camberwell New-road.
Hooley, Arthur, L.R.C.P. Edin., Cobham.
Houghton, F. E. Caulfield, Dudley.
Jones, Robert Langford, L.S.A., Bangor.
Loynd, William, Gt. Harwood.
Matthews, Samuel Richard, Llandinabo.
Oates, John Harrison, Dewsbury.
Poett, Patrick Matthias, L.K. & Q.C.P. Irel., Teremire, Dublin.
Prendergast, Joseph Moran, L.S.A., Melbourne, Australia.
Sellers, William, M.D., Radcliffe, Manchester.
Sharples, William Henry, Preston.
Stanwell, William, Rochdale.

The following gentlemen were admitted Members on Wednesday last:—

Bell, William Taylor, Totteridge Park.
Bond, Richard Pratt, L.R.C.P. Edin., Cheltenham.
Brown Percy, L.S.A., Camberwell.
Chronnell, James, Manchester.
Field, C. A. E. Adolphus, Camden-road.
Gardner, James Clark, Newcastle-on-Tyne.
Liddard, Sydney Robert, Dulwich-road.
Marshall, James, Plymouth.
Puddicombe, Francis Morgan, Dartmouth.
Roberts, Frank Ernest, Lower Norwood.
Shepherd, T. A. Jordan, L.S.A., Rotherhithe.
Voisin, Alexander Bishop, Jersey.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on Jan. 13th:—

Conway, Thos. Henry, New Burwell, Newcastle-on-Tyne.
Sumner, Joseph Henry Startees, Redburn-street, Chelsea.

THE salary of Mr. Ilott, medical officer of the Whitechapel Union Infirmary, has been increased from £200 to £250 per annum; and that of Dr. Knox, senior resident medical officer of St. Matthew Workhouse, Bethnal-green, from £200 to £250. The West Ham Board of Guardians have raised the salary of Dr. Scoresby-Jackson, Medical Officer for Walthamstow, to £150 per annum.

MANCHESTER MEDICAL SOCIETY.—At the annual meeting of the Society held at the Owens College on Jan. 12th, the following office-bearers and members of committee were elected for 1881:—President: Mr. Edward Lund. Vice-Presidents: Mr. John Broadbent, Dr. James Hardie, Dr. George Stevenson, and Mr. Walter Whitehead. Treasurer: Mr. F. A. Heath. Secretary: Mr. Chas. Jas. Cullingworth. Honorary Librarian: Mr. Thomas Windsor. Other Members of the Committee: Drs. Henry Ashby, Julius Dreschfeld, Arthur Gamgee, Charles Edward Glascott, Robert Hopwood (Stalybridge), Thomas Jones, John Dixon Mann, Henry Colley March (Rochdale), Siegmund Moritz, Joseph Chadwick Peatson, Edwin Rayner (Stockport), and William Yeats. (The above, with the past presidents of the Society and two representatives from the council of Owens College, form the committee.) Auditors: Drs. Abraham Matthewson Edge and Alexander Hodgkinson. Editor of the Society's proceedings: Dr. Charles Edward Glascott. The report stated that the number of members now on the roll is 219, as compared with 208 last year. 1357 volumes have been added during the past year to the library, which now numbers (excluding duplicates) 25,252 volumes.

LIVERPOOL MEDICAL INSTITUTION.—At the annual meeting on Tuesday, Jan. 11th, the following list of officers and council was adopted, the newly elected being those proposed by the council for ballot:—President: Mr. Reginald Harrison. Vice-Presidents: Dr. Caton, Dr. Dickinson, Dr. Gee (newly elected), and Mr. Townson (newly elected). Hon. Treasurer: Dr. W. M. Campbell. Hon. General Secretary: Mr. Rushton Parker. Hon. Secretary, Ordinary Meetings: Mr E. A. Browne. Hon. Librarian: Dr. Howie. Council: Dr. Barr, Mr. Banks, Mr. McCheane, Mr. Ransford, Dr. Rawdon, Dr. Waters, Dr. Burton (newly elected), Dr. Costine (newly elected), Dr. Cregeen (newly elected), Dr. Hicks (newly elected), Dr. Hoppey (newly elected), and Mr. Paul (newly elected). Microscopical Committee: Dr. Alexander, Dr Braidwood, Dr. Briggs (newly elected), Dr. Glynn, Dr. Grossmann (newly elected), Dr. Hicks, Mr. Newton, Mr. Rushton Parker, Mr. Paul, and Dr. W. Williams (newly elected).

SOCIETY FOR RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.—The usual quarterly court of the Directors of the above Society was held on Wednesday, Jan. 12th, at 5 P.M. Mr. John Gregory Forbes, V. P., in the chair. A sum of £1270 was awarded to fifty-nine widows, fifteen orphans, and three recipients of relief from the Copeland Fund. The expenses of the quarter were £63 2s. 6d. There were no fresh applicants for ordinary grants, and one only for extra relief from the Copeland Fund. Two new members were elected and the death of one was announced.

MR. J. WHITE HOPKINS, of the Swinnerton District of the Stone Union, has received a first-class grant for successful vaccination.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning, at the latest*

CASSON, H., M.R.C.S.E., has been appointed Medical Officer to the Stapleford District of the Wilton Union, vice Straton, deceased.

CUNNINGHAM, A., M.B., C.M., has been appointed Medical Officer of Health for the Oldbury Urban Sanitary District.

FARRAR, C., L.F.P.S.G., L.S.A.L., has been appointed Medical Officer to the Fourth District of the North Witchford Union.

FURNIVALL, C. H., M.R.C.S.E., L.S.A.L., has been appointed Medical Officer of Health for the District of Acton.

HOOPER, A., M.R.C.S.E., L.S.A.L., has been appointed Medical Officer of the Burton-on-Trent District and Workhouse of the Burton-on-Trent Union.

KAY, T. V., L.R.C.P.Ed., L.R.C.S.Ed., L.F.P.S.G., L.S.A.L., has been appointed Medical Officer and Public Vaccinator to the Clay Cross District of the Chesterfield Union, vice Wilson, deceased.

MILLER, W. J., L.R.C.P.L., M.R.C.S.E., has been appointed House-Surgeon to the Royal London Ophthalmic Hospital, Moorfields.

OGILVIE, L., M.B., B.Sc., has been appointed Extra Physician to the North West London Free Dispensary for Sick Children.

WILLIAMS, DAWSON, M.B., M.R.C.S.E., has been appointed Medical and Surgical Registrar to the Victoria Hospital for Children, vice Beckingsale, resigned. [In our last issue the Christian and surname were accidentally transposed.]

Births, Marriages, and Deaths.

BIRTHS.

ELLISON.—On the 13th inst., at Blythe House, Forest-hill, the wife of Frederick W. Ellison, M.R.C.S.E., of a son.

SHELDON.—On the 14th inst., at Cornwall-road, Notting-hill, the wife of Thomas Sheldon, M.D., of a son.

TICEHURST.—On the 8th inst., at Silchester House, St. Leonard's-on-Sea, the wife of A. R. Ticehurst, M.R.C.S.E. &c., of a son.

MARRIAGES.

DANIELL—KIRKMANN.—On the 19th inst., at St. Mark's, Kennington, by the Rev. W. Griffiths, M.A., Herbert E. Daniell, M.B., eldest son of the late Alfred Daniell, Esq., Surgeon, to Edith, youngest daughter of the late W. Kirkmann, Esq.

HOBSON—WATTS.—On the 13th inst., at St. John's Church, Broughton, Manchester, John Morrison Hobson, M.D., of Addiscombe Villas, Lower Addiscombe-road, Croydon (son of the late Dr. Benj. Hobson, of China), to Emily Ashton, eldest daughter of Joseph Watts, Esq., of Lower Broughton, Manchester.

DEATHS.

COOPER.—On the 8th inst., at South-hill-park, Hampstead, Thomas Henry Cooper, M.R.C.S.E., eldest son of Thomas Cooper, Esq., late of Well-walk, Hampstead, aged 33.

CRUCKNELL.—On the 14th inst., at Epsom, after a long illness, H. H. Cracknell, M.D., Fellow of Oriel, Oxford, aged 50.

GIBSON.—On the 29th ult., at Auteuil, Paris, Ida, second daughter of William Gibson, M.D., of Campbeltown, Argyll, aged 18. Friends are requested to accept this, the only intimation.

IRONSIDE.—On the 16th inst., at Edinburgh, Surgeon-Major William Ironside, M.D., Army Medical Department.

KERR.—On the 19th inst., suddenly, William Kerr, L.R.C.P.Ed., L.F.P.S.G., of 30, Vauxhall-walk, Lambeth, S.E., aged 37. Deeply regretted.

MOORE.—On the 17th inst., at his residence, 3, Queen-street, Lancaster, J. Daniel Moore, M.D., after a lingering illness, aged 46.

TIMS.—On the 8th inst., at North-street, Langport, Thomas Lamb Tims, L.R.C.P.Ed., M.R.C.S.E., L.S.A.L. Relatives and friends will kindly accept this intimation.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

INTERNATIONAL MEDICAL CONGRESS.

LONDON, AUGUST 2ND TO 9TH, 1881.

SECTION IV.—MEDICINE.

Sir WILLIAM WITHEY GULL, Bart., D.C.L., LL.D., F.R.S., President.

Professor W. T. GAIRDNER,
Dr. GEORGE JOHNSON, F.R.S.,
Dr. RICHARD QUAIN, F.R.S.,
Dr. WILLIAM ROBERTS, F.R.S., } Vice-Presidents.

Dr. DYCE DUCKWORTH,
Dr. WILLIAM M. ORD, } Secretaries.

Proposed List of Subjects for Discussion.

1. Localisation of Disease in Brain and Spinal Cord, so far as pathognomonic and diagnostic.
2. Trophic changes of Nerve-origin.
3. Vascular changes, functional and organic, in Disease.
4. Primary diseases of the Lymph-system.
5. Gout, Rheumatoid Arthritis, and Rheumatism.
6. Forms of Renal Diseases (Bright's Diseases).
7. Methods of Physical Diagnosis.
8. Therapeutic Methods:—Revulsions, Blood-letting, Diet-cure, Uses of Heat and Cold, Drug-cure, &c.

All communications regarding Section IV. should be addressed to Dr. ORD, 7, Brook-street, Grosvenor-square, London, W.

SECTION I.—ANATOMY.

Prof. FLOWER, LL.D., F.R.S., President.

Prof. MACALISTER, M.D.,
Prof. ROLLESTON, M.D., F.R.S.,
Prof. TURNER, M.B., F.R.S., } Vice-Presidents.

Prof. CURNOW, M.D.,
Prof. THANE, } Secretaries.

This Section will receive communications relating to any of the following subjects:—1. Human Anatomy, descriptive, microscopic, and topographical; 2. Embryology and Teratology; 3. Anatomical Anthropology and Anthropometry; 4. Comparative Anatomy in so far as it illustrates structural arrangements in Man; 5. Improved Methods of Instruction in Anatomy, and of preparing and preserving Anatomical Specimens.

Medical Diary for the ensuing Week.

Monday, Jan. 24.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

MEDICAL SOCIETY OF LONDON.—8½ P.M. Second Lettsomian Lecture: Sir Joseph Fayrer "On Tropical Dysentery and Diarrhœa."

Tuesday, Jan. 25.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 3 P.M.

ROYAL INSTITUTION.—3 P.M. Professor Edward A. Schäfer, "On the Blood."

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8.30 P.M. Dr. Ransome, "On Further Observations on the Value of Stethometry in the Prognosis of Chest Disease."

Wednesday, Jan. 26.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1 P.M.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

ASSOCIATION OF SURGEONS PRACTISING DENTAL SURGERY.—8½ P.M. Annual General Meeting.—Mr. W. A. N. Cattlin, "On the Imperfections of the Dentists Act, with suggestions as to the Alterations required to protect the interests of qualified Surgeons."

HUNTERIAN SOCIETY.—8 P.M. Mr. Waren Tay, "On a case of Colotomy."—Mr. Gilbert, "Notes on Cases in General Practice."

SOCIETY FOR THE ENCOURAGEMENT OF ARTS, MANUFACTURES, AND COMMERCE.—8 P.M. Mr. Edmund Johnson, "On Five Years' Experience of the Working of the Trade Marks' Registration Act."

Thursday, Jan. 27.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

ROYAL INSTITUTION.—3 P.M. Mr. Francis Hueffer, "On the Troubadours."

Friday, Jan. 28.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—9 P.M. Dr. Schuster, "On Modern Spectroscopy."

QUEKETT MICROSCOPICAL CLUB.—8 P.M. Mr. B. W. Priest, "On Sponges."—Dr. T. S. Cobbold, "On Filaria."

CLINICAL SOCIETY OF LONDON.—8½ P.M. Dr. Sutherland, "On a Case of Chronic Vomiting, in which no food except Koumiss was taken for sixteen months."—Mr. Hulke, "On the Results of a Trial of Chian Turpentine as a reputed Remedy for Cancer of the Female Genital Organs, conducted during several months of 1880 in Whitbread Ward, Middlesex Hospital."—Mr. J. W. Teale (Scarborough), "On a Case of Quiescent Scirrhus."—Mr. Heath, "On a Case of Gangrene of the Arm from a Poisoned Wound; Amputation at the Shoulder, and Recovery."—Dr. Whipham, "On a small Round-celled Sarcoma of the Dura Mater encroaching on the Left Temporo-sphenoidal Lobe of the Brain, and producing Extensive Softening in its neighbourhood; Absence of Aphasia, the Patient being Left-handed."

Saturday, Jan. 29.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—3 P.M. Mr. Sidney Colvin, "On the Amazons: A Chapter in the Study of Greek Art and Mythology."

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, January 20th, 1881.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radiation in Vacuo	Max. Temp. Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Jan. 14	29·85	N.E.	24	..	..	27	20	..	Foggy
,, 15	29·85	W.	17	..	..	28	10	..	Foggy
,, 16	29·79	S.W.	20	..	..	29	18	..	Foggy
,, 17	29·85	S.E.	23	..	..	32	16	..	Foggy
,, 18	29·32	E.	32	..	..	32	27	..	Overcast
,, 19	29·27	E.	28	..	..	29	25	..	Overcast
,, 20	29·97	E.	22	..	..	31	18	..	Foggy

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

THEOLOGY AND MEDICINE.

THE *Echo* gives currency to the following singular statement:—"The parish priest of Sendosni, in the diocese of Lerida, Spain, has declared from the pulpit that the last absolution, extreme unction, and Christian burial will henceforward be refused to any parishioner who allows himself, or whose kindred allow him, to be treated by any but duly qualified medical practitioners. All men, women, or children who are treated homœopathically will be deprived of the rites of the Roman Catholic Church, and treated as Moors or Jews."

SEWERS AND MILK.—DIPHTHERIA.

To the Editor of THE LANCET.

SIR,—In the last number of THE LANCET it is stated that the recent outbreak of diphtheria at Surbiton may be attributed to "foul water" from a well "occasionally used," which, it is inferred, "was reserved for dairy purposes." When first called in I warned the dairymen against using the well-water, and he assured me that it was never used "for dairy purposes." In the scullery, close to the door of the dairy, I observed a large sized earthenware pipe in direct communication with the soil drains running into the main sewer, which had been overlooked by the sanitary officials, and from this drain-pipe the deceased girl complained of having "swallowed the smell," of which she sickened immediately afterwards.

I am informed now that another dairy is supposed to be spreading this disease. How is it that the diphtheria should be confined to Surbiton, while the dairymen are supplying all the surrounding neighbourhood, including the Metropolitan Convalescent Institution for Children, without infecting any of them?

I have attended many cases, in all of which I can prove that the disease originated from the drains, and not from the milk, which was supplied from a variety of dairies, added to which I have treated every case as arising from drains, and none of the casualties have been amongst my patients, for the death in the dairyman's house was not from diphtheria.

There is only one ventilator in the drains throughout the populous part of Surbiton, and these drains are at times poisonous. Their condition was thus described by a resident on the 24th December last:—"I had three servants ill with gastric fever. I called in the inspector of nuisances, and he at once saw that I was ventilating the entire neighbourhood, and advised that a trap should be placed at my junction with the main sewer. I shall never forget the rush of foul air that took place when the junction was broken. The workman was driven backwards, and his candle put out, and I was made quite sick by the stench." This gentleman disconnected the sewer from his own house, and as there was no extra ventilator provided, the neighbours are the sufferers.

It is evident that with the drains of Surbiton in the condition above described—charged with "stench"—we cannot hope to escape diphtheria and other contagious diseases at certain periods; and it appears an absurdity to me to ascribe the existing sickness to milk. I have suggested that the Government sanitary engineer should be consulted as to the propriety of introducing ventilators into the drains, but the local authorities do not appear willing to adopt this measure. Some years ago ventilators were introduced into the drains of Kingston at my suggestion, with satisfactory results.

It would be interesting to know the opinion of the profession as to the necessity of burning the bedding and stripping the paper from the walls of a house where there has been a case of diphtheria.

I am, Sir, your obedient servant,

Sutherland House, Surbiton, Surrey, Jan. 5th, 1881. ROBT. COLLUM, M.D.

"THE CUP" AT THE LYCEUM.

MR. IRVING as Synorix in this tragedy, after having swallowed the fatal draught at the hands of Camma, and feeling death approaching, says:—

"I pray you lift me,
And make me walk awhile, I have heard
These poisons may be *walked down*: my feet
Are tons of lead."

He is then partially raised by one of his retinue, but dies apparently in convulsions, with marked opisthotonos; on the contrary, Miss Ellen Terry as Camma, who has also swallowed the same draught, but less of it, lives long enough to see Synorix die, and then expires herself *quietly* in the arms of one of her handmaidens. The phrases "I have heard these poisons may be walked down" and "My feet are tons of lead" are certainly indicative of opium poisoning, but why the death convulsions? and why the difference in the mode of death in the two victims?

INDIAN MEDICAL SERVICE.

To the Editor of THE LANCET.

SIR,—The leading article in your issue of October 2nd, 1880, on the above subject, while it draws attention to its genuineness as a service, does not sufficiently note the harm which will come of the recent orders in a professional point of view—that aspect which it most concerns a purely medical journal to keep an eye upon. Nay, it even intensifies one of the mistakes. There has been no complaint, so far as I am aware, that sanitary commissioners are not fully recognised, but rather the reverse. By the recent orders, whereby the prizes of the service are given to sanitary officers, it is lamentably clear that high professional qualifications are at a discount. Those very qualifications for which we are educated, selected, and imported into India at great expense to ourselves and to the State, and which it "pays" the State to secure and to utilise, are apparently not held in such high estimation or deemed so worthy of reward as a vague general knowledge of what is good for health. If a sanitary commissioner is to be promoted to the rank of deputy surgeon-general after twenty-six years' service, it seems strange to withhold it from the principals and professors in the presidency colleges of the same standing, or in fact from any man of acknowledged ability and professional skill.

Far be it from me to undervalue sanitary science, but sanitary science as required in India cannot for a moment be compared in value or in scale with good professional knowledge and practical skill. It is in a most elementary state. A man need not have much medical knowledge or any special education at all to be a sanitary officer in India. Before now sanitary commissioners have been "laymen," and though perhaps such a thing may not occur again, yet sanitary commissioners cannot even now lay claim to any high special knowledge. They are liable to be contradicted, or differed from, or involved in an argument with any omniscient administrator who "fancies" himself in sanitary matters, and the professional man does not always get the best of it, as witness many points during the late famine.

And even now, after the dismal experiences of that time, so little is medical opinion regarded in State affairs or scientific sanitarianism, that the late Famine Commission, which has been roaming about and deliberating in various parts of the empire, at an enormous expense, the prime object of whose cogitations was the saving of human life, was composed entirely of "laymen." The results of their labours have just been given to the world, and for this very reason, however important they may be generally, are in great part shorn of their worth and value.

But Government in India is eminently unscientific and rather see-saw, and this is a notable instance of it. At one time the amount of medical knowledge in a sanitary commissioner is thought so little of that a layman is appointed to the office; at another it appears to be so much appreciated that not only is he to be a medical man, but he is to be held worthy of high reward among his own brethren. And here it is, I think, that medical journals should point out the mistake that is being made, and should not fail to insist that if honours are to be given to medical men, it should be primarily for high professional ability, and not for such qualifications as an Indian sanitary officer need have.

Hitherto the Indian Medical Service has not been wanting in skilful and well-accomplished men, but it is inevitable that professional knowledge would decline where it was not properly recognised and rewarded. At all events, men who possess it in high degree, and who are distinguished in the practice of their profession, should not be liable to departmental supersession.

I am, Sir, yours, &c.,

India, Oct. 28th, 1880. SURGEON-MAJOR, I.M.D.

The Littlehampton Provident Dispensary.—We have frequently expressed our disapproval of dispensaries conducted by one medical officer at very low fees.

Dr. Rae's paper is marked for insertion.

A Young Practitioner.—The case is probably a neurotic one. Morphia, chloral, and all such remedies are to be shunned as likely ultimately to make matters worse. Tonics, change of air and circumstances, and the expression of a hope that with advancing years pain will be less, are the principal measures to be recommended.

M.R.C.S.—We think our correspondent is right on both points. To absolutely refuse consultation with a qualified practitioner would be doubtful ethics, and would certainly be bad policy. It would excite a charge of "trades unionism," &c. Consultations should be taken only on dignified terms. The scheme adopted is a bad one, and has frequently had our disapproval. Working men and their wives are not likely to be long satisfied with a doctor chosen by others and on terms unremunerative to the surgeon appointed and disrespectful to practitioners of standing in the town.

Mr. Hilles.—It would be better, we think, to postpone the publication of the description until the instrument has been tested.

Mr. C. C. Burman.—Soon.

A Pupil is referred to the article on Books in our Students' Number.

Mr. G. A. Warren should consult his usual medical attendant.

ORCHITIS AS A CONCOMITANT AND SEQUEL OF MEDITERRANEAN FEVER.

To the Editor of THE LANCET.

SIR,—Among the remittent fevers that in almost every part of the globe affect the health of our imperial forces on land and sea there is none probably that cause so high a ratio of invaliding and individual inefficiency as that peculiar type best known under the name of Mediterranean fever. Seldom fatal in its result, but insidious in its approach, it too often leaves its victim a mere wreck of his former self, and when at last, after vainly endeavouring to shake it from him, he seeks a remedy by returning home to breathe his native air, he finds for months his limbs attacked by neuralgic pains, and his movements crippled by rheumatic joints. As it has been often noted that these remittent fevers differ one from another in some respects according to the localities in which they have been contracted, and have many of them a certain individual stamp, so we find in this particular variety to which I am alluding a marked tendency to rheumatic affections of the different organs and tissues of the body.

During the early part of this year I had the honour of serving on board of one of Her Majesty's ironclads in the Mediterranean, and spending some months lying in the harbour of Calcutta without moving, had an opportunity of studying a slight outbreak of this fever among her crew.

Invaliding from foreign stations naturally removes from under the eye of the medical officer many of his worst cases, and their sequel is consequently lost to him, but out of twenty-three cases occurring on board, four suffered from what I believe to be not a common complication, and one which is the subject of this letter—viz., a rheumatic affection of the testis and neighbouring structures. In two of the patients the affection ushered in the disease after a few days' premonitory symptoms, and in the others it followed as a sequel, in one case three months, in the other four, after the acute stage of the fever had passed away, and while they were still labouring under the debility consequent upon the attack. In all of them the body of the testis was the first part affected, the organ rapidly enlarging, and testicular sensation being much impaired after two or three days. Subsequently the inflammation extended to the epididymis, and in one of the cases a hydrocele made its appearance on the same side, and was tapped. The disease was confined to one side. Under appropriate treatment the inflammation, which was very considerable in all of them, resolved, and the infiltration of the testes and epididymitis, which were great, disappeared in a rapid and marvellous manner, leaving the organs intact.

I will not even hazard an opinion on the nature of the *materies morbi* in this fever, which singles out the fibrous tissues of the body for its attacks, producing often excruciating neuralgia by affecting the neurilemma of the nerves, impairment of the joints by affecting their tendinous surroundings, and in a similar manner, is frequently the cause of effusions into the pericardia and pleuræ. Is it analogous to that of ordinary rheumatic fever? This is a question to be solved by those eminent pathologists the results of whose researches in all parts of the world are daily adding fresh knowledge to our craft. I am only a simple recorder of facts, and leave deductions to them.

I am, Sir, yours obediently,

H. M. ELLIS, R.N.

Royal Marine Artillery, Eastney, Dec. 17th, 1880.

Mr. J. S. Grubb.—As the question is put, we should say the guardians have no such power.

F.R.C.S.I. has not enclosed his card.

Mr. Malcolm Morris's lecture will appear in an early number.

THE TERMS OF ATTENDANCE ON ODDFELLOWS.

To the Editor of THE LANCET.

SIR,—I shall be much obliged if any of your readers can tell me of any lodge of Oddfellows which pays its medical officer more than four shillings a year for each member, also if the fee includes attendance in cases caused by intemperance, such as delirium tremens, and how long a distance from the lodge the medical officer is expected to attend. Information upon the above points will greatly oblige.

I am, Sir, yours faithfully,

Ben Rhydding, Jan. 19th, 1881. F. D. LITE.

STIMULANTS IN WORKHOUSES.

AT a recent meeting of the Prestwich Board of Guardians a discussion arose upon the subject of the consumption of stimulants in the workhouse, and Mr. Basil Cane, Local Government Board inspector, who was present, on being appealed to for his opinion, said he had seen good results follow the supply of drugs by the guardians themselves, because it relieved the medical officer of the inducement to do with wine and spirits—paid for by the union—what he would otherwise have effected with drugs. If the guardians supplied the latter there would probably be a reduction in the bill for stimulants.

"PREMATURE LABOUR INDUCED BY QUININE."

To the Editor of THE LANCET.

SIR,—I see in the number of your journal received last mail a short article on the above subject by Mr. E. Downes, and as lately I have had an exactly similar case, with an opposite result, I think it may be of some interest to record it.

The patient, aged twenty-seven, was seven months' gone in her fourth pregnancy, and was brought to an extremely debilitated and anæmic condition from repeated attacks of ague. Quinine was prescribed, at first in small doses, and subsequently increased to twenty grains per day, and continued for about three weeks. The attacks of fever disappeared under its influence, and she has now arrived almost at her full time, without any uterine disturbance of any sort, while taking the drug.

During a severe epidemic of malarial fever last year in Rangoon I had an opportunity of giving quinine in several like cases, and never saw any attempt even at the induction of labour, though I am aware that it is sometimes reputed to act in this manner.

I remain, Sir, yours faithfully,

H. A. FOGERTY, M.D., Surgeon, A.M.D.

Meerut, India, Nov. 8th, 1880.

To the Editor of THE LANCET.

SIR,—Mr. Downes's letter from Kashmere, published in your issue of the 16th October last, regarding the induction of premature labour by quinine, induces me to mention a case which occurred recently. I was called to see a lady in her eighth month of pregnancy. She had two severe attacks of the tertian type before I saw her. I tried arsenic in full doses, but without benefit. I then gave her three-grain doses of quinine twice a day with Fowler's solution and tincture of opium, but without effect. She had had by this time six attacks, and felt pain in the back, loins, and down the thighs. The last two attacks of fever were very severe, with delirium. I therefore decided to give a fairly large dose of quinine, and accordingly administered ten grains, with ten minims of tincture of opium, at 4 o'clock on the morning of the fever day. It was at once checked without a bad symptom. I repeated the dose in the morning of the next expected attack, and gave three grains, with eight minims of tincture of opium, on the intermediate day, with the best result.

Fever doubtless causes premature labour. I had a case last year in which, without quinine, the membranes burst during fever, but labour did not occur for a week after. The fever was then of eight days' duration (remittent, with insensibility), which on the eleventh day subsided. This patient was confined of a seven months' child, which did not survive its birth more than thirty hours. I have always given quinine, combined with tincture of opium, in all periods of pregnancy, and cannot call to mind any case where it produced abortion or premature labour. I believe that tincture of opium modifies, or entirely checks, any reputed or real cobolic action of the alkaloid. Arsenic takes time to act, and the delay allows of the fever poison operating in the specific manner now generally admitted.

I am, Sir, yours faithfully,

W. J. LINCOLN, L.R.C.P., &c.,

Mysore, Nov. 17th, 1880. Civil Surgeon.

ON THE ASSOCIATION OF AFFECTIONS OF THE THROAT WITH ACUTE RHEUMATISM.

To the Editor of THE LANCET.

SIR,—I have only just seen the paper of my friend Dr. J. K. Fowler on the above subject in THE LANCET of December 11th, and also the letter of my former colleague, Mr. Lennox Browne, in the issue of the 25th December. I should like to be allowed to bear corroborative testimony as to the apparent connexion, which I have frequently noticed, between rheumatism and certain throat affections, tonsillitis especially. My attention was first drawn to the point by Mr. Lennox Browne, some four years ago, when I was acting as his clinical assistant, and I have observed it in many cases since. In almost all cases of tonsillitis which I have treated since that time I have prescribed salicylate of soda, in combination with sulphate of magnesia, and sulphate or salicylate of iron, usually with very excellent results. Patients who have had tonsillitis several times before have assured me that they had never previously got over an attack so quickly as they did under this treatment. As far as my reading goes, I think Mr. Lennox Browne was the first to note—certainly the first to emphasize—the etiological, semeiological, and therapeutic analogy between tonsillar inflammations and the arthritic diathesis. It is valuable and interesting to have the corroborative independent testimony of such an evidently careful observer as Dr. Fowler.—I am, Sir, yours obediently,

DOUGLAS HEMMING, F.R.C.S. Ed.

Bournemouth, Dec. 31st, 1880.

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LETTERS, *each with enclosure*, are also acknowledged from—Mr. Gowan; Mrs. Reynard, Gainsborough; Mr. Cave, Bromyard; Messrs. Tabor, Lujan; Mr. Hannah, Lancaster; Mrs. Gisburn, Hunslet; Mr. Nellah, Ripley; Dr. M'Cartie, Carrig Navad; Mr. Chadwick, Islington; Dr. Spouncer, Gainsboro'; Mr. Mason, Hitchin; Dr. Camming, Portland, U.S.A.; Mr. Hine, Eppinsdale; Mr. Purcell, Feakle; Mr. Gardner, Edinburgh; Mr. King, Leighton Buzzard; Mr. Woodcock, Bradford; G. H. O.; Medicus, Killamarsh; Zeta; J. R. P., Leicester; Physician, Eccleshall; A. B., Stow-on-the-Wold; A. B. S., Dudley; G. H. W.; T. H. J., Ilford; H. H., Wednesbury; Medicus, Tunstall; Amicus; C. E. G.; Medicus, Ashton-under-Lyne; Medicus, Hackney; Myopia; M.D., Gower-street; B.A., Leeds; Medicus, Penrhyn Coch; &c., &c.

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Tables of Contents, with the Index of Advertisements, for each Number can be had on application to the Publisher.

Agent for the Advertising Department in France—J. ASTIER, 67, Rue Caumartin, Paris.

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